Mentally Ill Offender Crime Reduction Grant Program

Annual Legislative Report
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California Board of Corrections

MENTALLY ILL OFFENDER

CRIME REDUCTION

GRANT PROGRAM

ANNUAL LEGISLATIVE REPORT
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EXECUTIVE SUMMARY

In an effort to improve California's response to the cycle of recidivism among mentally ill adult offenders, the Legislature passed Senate Bill 1485 (Chapter 501, Statutes of 1998), which established the Mentally Ill Offender Crime Reduction Grant Program.

SB 1485 directed the California Board of Corrections (Board) to award grants supporting the implementation and evaluation of locally developed demonstration projects designed to reduce crime, jail crowding and criminal justice costs associated with mentally ill offenders.

SB 1485 also directed the Board to evaluate the overall effectiveness of these projects and report findings to the Legislature annually (Penal Code Section 6045.8). This second annual report on the Mentally Ill Offender Crime Reduction Grant Program complies with that requirement.

Senate Bill 2108 (Chapter 502, Statutes of 1998) provided $27 million to launch the Mentally Ill Offender Crime Reduction Grant Program, and the 1999/00 State Budget included $27 million to expand the program. These two appropriations resulted in grants totaling over $50.6 million to the following 15 counties:

Humboldt	Riverside	San Mateo
Kern	Sacramento	Santa Barbara
Los Angeles	San Bernardino	Santa Cruz
Orange	San Diego	Sonoma
Placer	San Francisco	Stanislaus

The projects undertaken by these 15 grantees address an array of in-custody and post-custody needs identified by counties during the multi-agency planning process required by SB 1485 in order to be eligible for a demonstration grant.

The interventions implemented by counties in response to these needs include dedicated in-custody housing; pre-release planning; intensive case management and supervision; referrals to mental health and other service providers; help in securing housing, education and/or vocational training, employment, and financial entitlements; individual/group counseling; life skills training; substance abuse education; drug testing; medication education and management; crisis intervention; transportation; day treatment; drop-in centers; and court monitoring.

While all 15 projects are now fully operational, the time-consuming nature of start-up activities – recruiting, hiring and training staff and finding program sites, among other things – and the comprehensive assessment process required to determine program eligibility have impacted the rate of client enrollment.

Over the course of the four-year grant period, approximately 9,200 offenders will participate in the evaluation component of these projects. Over half of these individuals will receive enhanced services; the remainder will receive treatment as usual. Through December 2000, counties had enrolled over 1,850 participants. Client intake data for the January through December 2000 time period indicates that:

- The average age of participants is 38 years, approximately 62 percent of participants are male, and the most prevalent ethnicities or races are White, Black and Hispanic.
- At the time of program entry, approximately 20 percent of participants were homeless and approximately 30 percent of participants were unemployed.
- Depressive and bipolar disorders are the most common diagnoses of mental illness, followed by schizophrenia/other psychoses.
- The majority of participants indicate that they had adequate food, clothing, shelter, and other basic resources during the 30 days prior to the qualifying arrest.
- The mean number of bookings during the 36 months prior to program entry is 4.3, and the median number of days in jail during the 36 months prior to program entry was 54 days.

Although an insufficient amount of data has been collected at this point in the program to analyze the effectiveness of these projects, anecdotal evidence provided by counties indicates that clients are responding well to enhanced services. In time, the data being reported to the Board, along with findings from each county's project evaluation, will provide much-needed insight on effective strategies for curbing recidivism among mentally ill offenders.

PROGRAM HISTORY

In 1998 the California State Sheriffs Association and the Mental Health Association of California spearheaded an effort to reduce the number of mentally ill individuals who repeatedly commit offenses, often because they are not receiving the intensive services, supervision and support needed for successful community integration.

The result of this effort was passage of Senate Bill 1485, which created the Mentally Ill Offender Crime Reduction Grant Program and directed the Board of Corrections (Board) to award four-year grants to counties for collaborative projects designed to determine – through state and local evaluations – the most effective strategies for reducing crime, jail crowding and criminal justice costs associated with mentally ill offenders (see Appendix A – Senate Bill 1485).

The Legislature initially provided $27 million to support the program (Senate Bill 2108), and set aside up to $2 million of this amount for non-competitive planning grants. These grants supported local collaborative planning efforts aimed at assessing the population of mentally ill offenders and determining the gaps in existing services for these individuals in the jail and/or upon their release from custody. In December 1998, the Board awarded planning grants totaling over $1.2 million to applicant counties.

Demonstration Grant Process: SB 1485 stipulated that demonstration grants be awarded by the Board on a competitive basis. To be eligible for a demonstration grant, SB 1485 required counties to form a Strategy Committee whose members included, at a minimum, the sheriff/director of corrections, chief probation officer, mental health director, a superior court judge, representatives from a local law enforcement agency and mental health service provider, and a client/consumer.

The Strategy Committee had to develop and submit a comprehensive plan describing the county's existing continuum of responses for offenders who are mentally ill, identifying gaps in programs and/or services, and outlining priorities for achieving a full continuum.

To ensure an equitable and valid demonstration grant process, the Board created an Executive Steering Committee (ESC) that considered input from subject matter experts and the public in developing the content, format and requirements of the grant application and proposal evaluation criteria (see Appendix B – Executive Steering Committee). In May 1999, following an extensive review of 40 proposals by the ESC, the Board adopted the recommendations of the ESC and awarded funds to seven counties.

The 1999/00 Budget Act allocated an additional $27 million to the program and specified that most of the money would support projects based upon the rankings previously established by the Board. The Budget also capped grants at $5 million and provided this amount to Los Angeles and San Francisco for projects targeting those mentally ill offenders most likely to be committed to state prison ("High Risk Models").

Participating Counties: As a result of funding provided by SB 2108 and the 1999/00 Budget Act, 15 counties received grants totaling over $50.6 million to implement and evaluate collaborative projects involving an array of jail and community-based interventions for mentally ill offenders (see Appendix C – Project Descriptions).[1] These 15 counties, and their respective grant awards, are outlined below.

COUNTIES	GRANT AWARD
Humboldt	$2,268,986
Kern	$3,098,768
Los Angeles	$5,000,000
Orange	$5,034,317
Placer	$2,139,862
Riverside	$3,016,673
Sacramento	$4,719,320
San Bernardino	$2,477,557
San Diego	$5,000,000
San Francisco	$5,000,000
San Mateo	$2,137,584
Santa Barbara	$3,548,398
Santa Cruz	$1,765,012
Sonoma	$3,704,473
Stanislaus	$1,713,490
TOTAL	**$50,624,440**

[1] The 2000/01 State Budget provides $50 million to expand the Mentally Ill Offender Crime Reduction Grant Program. In September 2000, the Board awarded planning grants to all applicants. Based on the recommendations of an Executive Steering Committee, the Board awarded demonstration grants to 14 counties in May 2001 (please see Page 10).

PROJECT IMPLEMENTATION

The counties participating in the Mentally Ill Offender Crime Reduction Grant Program are providing a broad array of enhanced services to seriously mentally ill offenders. These services address the offenders' in-custody and/or post-custody needs as identified by counties during the local planning process required by SB 1485.

The jail-based interventions that have been implemented include early identification and screening procedures; enhanced mental health assessments; case management and brokerage services; dedicated housing; and pre-release planning.

Enhanced services in the community include intensive case management and supervision; assistance in securing short and/or long-term housing, vocational training, employment, and financial entitlements; counseling; life skills training; substance abuse testing; medication education and management; transportation services; crisis intervention; and day treatment or drop-in centers. Some counties also created a mental health court or dedicated court calendar as a part of their demonstration project.

Collaboration: In establishing this program, the Legislature expressed its intent that the projects involve collaboration among law enforcement, corrections, the courts, mental health treatment providers and other community-based agencies. The value of such an approach has been confirmed in a national study indicating that cooperation and communication between law enforcement and mental health professionals, even when their goals and expectations appear to conflict, were among the factors most often cited as important to the success of programs similar to this one.[2]

Counties continually emphasize that they have benefited immensely from this collaboration – not only in developing and implementing these demonstration projects but also in addressing other issues and concerns in their communities relating to mentally ill offenders.[3]

The individuals collaborating on these projects – in some cases, to an unprecedented extent – include deputy sheriffs and correctional officers, deputy probation officers, judges, prosecutors, public defenders, psychiatrists, nurses, licensed clinical social workers, and substance abuse specialists.

All of these individuals, regardless of their different roles and perspectives, are genuinely committed to the goal of this program: reducing recidivism among mentally ill offenders, many of whom come in contact with the criminal justice system as a result of insufficient treatment, the nature of their illnesses, and the lack of social supports and other resources.

Start-up Activities: As has been typical with other grant programs administered by the Board, counties required an average of nine months to get their projects up and running.

According to grantees, one of the most time-consuming start-up activities is the recruitment and hiring of staff for the project (jail personnel, probation officers, mental health professionals, social workers and other critical personnel). County employment practices, the limited pool of qualified candidates (particularly in the mental health field), and the unique nature of the projects themselves (e.g., offering clients "24/7" access to staff) all prolonged the process of bringing essential staff on board. Counties also experienced delays in getting their projects fully operational due to an identified need to train and/or cross-train staff.

In addition, for some counties, finding an acceptable site for a residential treatment program and/or suitable office space for the case managers and other staff working with clients on a daily basis took longer than anticipated.

A few counties also found that it took more time than expected to finalize subcontracts with community-based providers of mental health services, board and care homes and other service agencies.

[2] Source: Psychiatric Services, January 1999.

Client Enrollment: In developing their demonstration grant proposals, counties relied on estimates of the number of mentally ill offenders in the jail population. However, what counties are discovering in screening individuals for potential participation is that many offenders, once they are no longer under the influence of drugs and/or alcohol, do not have a serious mental illness as their primary diagnosis, thus excluding them from the program.

Eligibility criteria established and approved by each county has also impacted the rate of client enrollment (see Appendix D – Client Eligibility Criteria).

Counties are identifying potential participants and conducting comprehensive assessments to determine if they meet eligibility criteria. This screening process has involved hundreds – in a few counties, thousands – of offenders. In the end, the vast majority is found ineligible, due in large part to having committed offenses the county excluded for pubic safety reasons.

Of the nearly 2,800 inmates screened in one county, for example, less than six percent met the criminal justice criteria. In another county, only 92 of the 548 offenders screened through December 2000 met the mental health, criminal justice and/or other criteria (e.g., residency).

The voluntary nature of these projects – i.e., any offender can refuse to participate – has also contributed to the fact that counties are serving fewer clients than expected at this point.

Operational Challenges: Not surprisingly, counties are also facing challenges in day-to-day program operations. Among these is the lack of appropriate and affordable temporary, transitional and/or long-term housing for clients. In response, counties are working to establish or expand ties with homeless shelters, motels, board and care facilities, and rental units.

Identifying effective treatment strategies for persons with a dual diagnosis (serious mental illness coupled with substance abuse), who comprise a large percentage of clients in many counties, is also challenging.

According to the National GAINS Center for People with Co-Occurring Disorders in the Justice System, the presence of co-occurring disorders indicates a poor prognosis for both involvement in treatment and compliance with medication, and is associated with higher hospitalization rates, more frequent suicidal behavior, and more pronounced difficulties in social functioning.

The National GAINS Center, which collects and disseminates information about effective mental health and substance abuse services for dually diagnosed individuals, also reports that there is a lack of community-based facilities equipped to treat this population.

Further, according to the state Department of Mental Health, the dually diagnosed population has higher rates of homelessness.

Changes in project management and line staff (clinicians, case managers, probation officers, etc.), whether due to burnout, promotions, or other reasons, also pose challenges. Although inevitable, staff turnover requires that additional time be focused on recruitment and hiring and places a heavier burden on remaining staff to ensure continuity of services for clients.

Although many challenges have surfaced with these demonstration grants, the counties remain firmly committed to implementing their projects with passion – and, as one client stated, with compassion.

"Project Redirection saved my life, literally. More importantly, it allowed me the opportunity to find some meaning or reason for living where none existed. The entire staff's professionalism, compassion and undying optimism is just unreal."

Client, Sacramento County
November 2000

[3] Several counties that did not receive a grant subsequently reported to Board staff that the collaboration involved in developing their proposal has had an ongoing positive impact.

This commitment has manifested itself in many ways – not the least of which is the time involved in serving clients. In San Diego County, for example, the members of five multi-disciplinary case management teams provide services to clients seven days a week between the hours of 7:30 a.m. and 6:00 p.m. and carry a 24-hour pager in order to respond to crisis situations as needed. This type of schedule is the rule rather than the exception in these projects.

A number of counties have also pursued specialized training opportunities for project staff. A team from one county participated in a conference sponsored by the National GAINS Center, and project staff from several counties attend the annual training conference sponsored by the Forensic Mental Health Association of California.

In addition, in the summer of 2000, the project manager for Stanislaus County initiated a major effort to bring together line staff, especially from counties using some adaptation of an assertive community treatment model in their projects, to exchange information and ideas. The result was an extremely well attended and well-received Best Practices Meeting.

Although it is much too early in the life of these projects to assess the efficacy of programmatic approaches and/or specific interventions in reducing recidivism among mentally ill offenders, anecdotal evidence provided by counties to Board staff indicates that clients are generally responding well to the enhanced services they are receiving (see Appendix E – Case Profiles).

"The firmness of the Probation Officer, the flexibility of the treatment program, and the regular and frequent visits with his Personal Service Coordinator have all served to keep Sam focused and involved in his treatment. (Their) collaboration. . . .has facilitated his treatment success and ensured that he abides by court orders."

Case Profile #2
Los Angeles County

ACT "Line Staff"
Best Practices Meeting
October 24-25, 2000

Staff working with the demonstration projects in 13 counties came to Sacramento to participate in this day and a half long meeting, which featured two special presentations by project personnel with special subject matter expertise.

Assertive Community Treatment (ACT): This presentation sought to enhance participants' knowledge and understanding of ACT, a multi-disciplinary team approach that assumes responsibility for directly providing acute, active and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support.

Substance Abuse Management: This session provided information and insight on serving dually diagnosed individuals.

The meeting also provided attendees an opportunity to network with their counterparts from other projects on specific topics of interest. These roundtable discussions, which resulted in a list of best practices, focused on:

- Collaboration between mental health, probation and law enforcement.
- Issues in client treatment surrounding quality of life.
- Post-release engagement strategies.
- Successful interventions with the dually diagnosed.
- Building a culturally competent program.

Evaluations from this meeting indicated that it was extremely helpful, both in terms of providing information that would enhance the ability of staff to serve clients and in allowing staff from the various counties to establish ongoing working relationships.

PROGRAM ADMINISTRATION

The Board approaches its many responsibilities, including the management of grant programs, by working in partnership with counties. In terms of the Mentally Ill Offender Crime Reduction Grant Program, this collaboration involves working closely with project managers, fiscal officers, evaluators and other staff to ensure the successful implementation of projects as well as the responsible administration of grant funds.

Project Oversight and Support: To keep the Board apprised of the progress counties are making with their projects and provide grantees any needed technical assistance, Board staff visits each county at least once every six months. These site visits provide an opportunity to observe program operations, discuss issues surrounding project implementation, and review data collection efforts. Board staff also receives semi-annual progress reports from each county identifying issues that may warrant technical assistance.

Regional Project Managers Meetings serve as another vehicle for Board staff to provide technical assistance. These sessions, hosted by a grantee, provide an opportunity for Board staff to share information on grant management activities and contract compliance issues.

The meetings also provide an opportunity for project managers, financial officers, evaluators, line staff and other key personnel to exchange information about the challenges and issues they are confronting, as well as the approaches that appear to be working with clients.

> *"Thank you for saving my life. That is all I have to say."*
>
> Client, Santa Cruz County
> Luncheon Guest Speaker
> October 2000 Project Managers Meeting

In addition to problem-solving discussions, each meeting includes project updates, and at least one presentation on an issue identified as being of interest to grantees (e.g., treating individuals with co-occurring mental health and substance abuse disorders, applying the principles of harm reduction, and operating a mental health court).

Based on written evaluations of these sessions, it is clear that they provide a valuable source of information sharing for grantees.

Fiscal Accountability: Counties participating in the Mentally Ill Offender Crime Reduction Grant program submit quarterly financial invoices to Board staff outlining the amount of state funds and local match funds expended on the project for that quarter and to date. To ensure that grantees have expended funds in accordance with the terms of the contract, each county must submit a final audit to the Board within 120 days of the contract ending date.

To assist counties in understanding their fiscal responsibilities, Board staff arranged for auditors with the Department of Finance's Office of State Audits and Evaluations to lead a discussion at the February 2000 Project Managers' meeting on a variety of issues related to contractual audit requirements.[4]

Board staff also requested the Department of Finance to conduct compliance reviews on the projects in five counties. These reviews, which concluded in January 2001, identified areas in need of improvement and/or change in order for counties to be in financial compliance with the provisions of their contracts – e.g., maintaining sufficient documentation on expenditures and insuring adequate internal controls.

So that all 15 grantees could benefit from this technical assistance process, Board staff shared the findings of these five compliance reviews, as well as an audit checklist developed and used by the Department of Finance in conducting both compliance reviews and audits, at the February 2001 Project Managers' meeting.

Web Site: To ensure access to information on this program for counties and other interested parties, and to facilitate project management, Board staff makes a concerted effort to publish timely and useful materials on the agency's web site at www.bdcorr.ca.gov. This information includes such things as project descriptions and county contacts, contract management forms, and program administration activities.

[4] To ensure appropriate fiscal oversight of this grant program, the Board has an Interagency Agreement with the Department of Finance for technical assistance and support services.

PROGRAM EVALUATION

The primary objective of the Mentally Ill Offender Crime Reduction Grant program is to determine "what works" in reducing crime, jail crowding and criminal justice system costs associated with the mentally ill offender population. Toward this end, SB 1485 requires the Board to evaluate the overall effectiveness of demonstration projects in relation to these outcome measures. In addition to the statewide evaluation, counties must assess the efficacy of their respective projects in meeting specified outcomes.

Statewide Evaluation: In fulfilling its mandate to evaluate this program, Board staff developed a research design, with considerable input and cooperation from funded counties, that requires grantees to collect and report common data elements concerning the target population (intake data), the services counties are providing to these individuals (intervention data), and the effects of the treatment interventions on curbing recidivism among offenders diagnosed with a serious mental illness (outcome data).

Counties submit these common data elements every six months. Board staff then combines the data to create a considerably larger sample size, which increases the statistical power of the research and the extent to which positive results can be generalized.

For this second annual report, Board staff analyzed data submitted by counties for the January through December 2000 period. Given the operational dates of these projects, this time period did not result in the collection of sufficient data for assessing the overall effectiveness of the treatment interventions implemented by counties. Thus, for this report, the Board's researchers analyzed the client intake data provided by counties and constructed a profile of the program's participants.

Participant Profile: The following profile is predicated on four sets of intake data submitted by all 15 grantees for the January to December 2000 time period: demographic characteristics, mental health status, available resources at the time of program entry, and criminal history.

As of December 31, 2000, there were a total of 1,857 mentally ill offenders participating in the demonstration projects. Of these, approximately 51 percent were receiving enhanced services. Although the absence of a full and/or accurate set of data for each participant precluded the computation of exact percentages for this profile, the Board's researchers constructed ranges of values within which the statistic lies (e.g., the proportion of whites in the population is between 58.4 and 61.8 percent). These intervals have been constructed such that the researchers are 95 percent certain that the ranges contain the true population statistic.

Demographic Characteristics

Age: The average age of participants is 38 years. While ages range from 19 to 74 years, approximately 95 percent of participants are between 19 and 57 years old. Male participants are on average 1.1 years younger than female participants.

Gender: The proportion of males enrolled in the program is between 62.4 and 62.6 percent; the range for females is between 37.4 and 37.6 percent. These ranges differ from the gender breakdown in the total jail population. Last year, for example, 87 percent of the jail inmates were male.[5] As explained by project staff, this difference may be attributable to the fact that many counties have excluded violent offenses (murder, rape, child molestation, etc.) in the eligibility criteria for program participation.

Ethnicity/Race: Table 1 identifies the three most prevalent ethnicities/races among project participants. While the database includes other ethnicities/races, none exceeds 2 percent of the population at this time.

Table 1: Ethnicity/Race

Ethnicity/Race	Representation
White	58.3 – 59.0
Black	21.7 – 22.2
Hispanic	13.6 – 14.0

[5] Jail Profile Survey: 2000 Annual Report

Marital Status: As indicated by Table 2, most of the individuals participating in the Mentally Ill Offender Crime Reduction Grant program either have never been married or were divorced or separated when they entered the program.

Table 2: Marital Status

Category	Percentages
Never married	54.1 – 55.9
Separated	9.9 – 11.0
Divorced	19.5 – 20.9
Married	11.2 – 12.3
Widowed	2.0 – 2.5
Remarried	<.5

Dependent Children: As can be seen from Table 3, most of the participants do not have any dependent children.

Table 3: Dependent Children

# Children	Percentages
0	67.1 – 69.6
1	11.4 – 13.3
2	7.7 – 9.2
3	5.0 – 6.3
≥4	4.5 – 5.7

Although this finding, coupled with the very low marriage rate shown in Table 2, presents the typical participant as a "loner" in the sense of disconnectedness with family, the Board's researchers cannot address the issue of whether familial isolation is a cause or an effect of illness and/or involvement with the criminal justice system.

Living Arrangements: At the point of contact with the projects, between 19.1 and 20.2 percent of participants were homeless. It is noteworthy that approximately half (between 49.8 and 51.2 percent) lived in a home or apartment without support of any kind at the time of the qualifying arrest.

Education: The Board's researchers estimate that the high school graduation rate (includes possession of a GED) of participants is between 34.5 and 36.0 percent. In addition, between 3.6 and 4.3 percent of the population indicates that they have received 16 years of education, the equivalent of a four-year college degree.

Employment: Between 28 and 33.7 percent of participants were unemployed at the time they entered the project. Researchers also estimate with 95 percent certainty that between 16.1 and 17.3 percent of all participants are engaged in some form of wage-earning employment (i.e., part or full time, competitive or sheltered).

Mental Health Status

All of the participants in this program suffer from a serious mental illness. These illnesses range across 119 categories of the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV). The most frequently occurring DSM-IV diagnostic codes are for the depressive and bipolar disorders, with a prevalence rate of between 48.2 and 48.9 percent. The second most commonly occurring disorders are those of schizophrenia and other psychoses, which afflict between 37.6 and 38.2 percent of participants.

To enhance the diagnostic process, counties are using multiple measures of personal and social functioning, including an individual's Global Assessment of Functioning (GAF) score. Higher GAF scores indicate a greater capacity to function in society.

Although GAF scores are spread throughout the entire breadth of the 100-point scale, the average (mean) for participants is 45, which is defined as serious impairment in social, occupational or school functioning. There are no meaningful differences in GAF scores between males and females or between the three most prevalent ethnic/racial groups.

Substance Abuse: Additional data reported by counties on clients' mental health status indicates that 73.9 to 76.0 percent of participants have a substance abuse problem (drugs, alcohol or a combination) in conjunction with a primary diagnosis of a serious mental illness (co-occurring disorder).

At the time of program entry, between 38.9 and 41.5 percent of participants report that they have problems with alcohol, and between 56.4 and 58.9 percent report problems with drugs.

Suicidal Risk: Existing suicide risk assessment procedures indicate that between 17.6 and 19.6 percent of participants are regarded as a suicidal risk at the time of their qualifying arrest

Available Resources

In examining the adequacy of basic resources available to clients, the Board's researchers considered food, clothing, shelter, transportation and social needs during the 30 days prior to the qualifying arrest. Researchers also examined whether participants received any financial support during the 12 months prior to the arrest qualifying them for the program. The results of these analyses, expressed in percentages, are presented in Table 4.

Table 4: Adequate Resources

Need/Resource	30 Days	12 Months
Food	68.0 – 70.2	
Clothing	60.7 – 63.0	
Shelter	59.6 – 61.9	
Transportation	57.2 – 59.3	
Social Needs	49.2 – 51.6	
SSI		37.4 – 39.9
Financial support from family /friends		24.2 – 26.4
SSDI		9.3 – 10.8
General Public Assistance		6.3 – 7.6
CALWORKS		2.9 – 3.9
Veterans' Administration		2.4 – 3.3
Pension		1.2 – 1.8

Data analyzed by the Board's researchers also indicate that between 32.8 and 36.6 percent of participants were receiving some form of public assistance at the actual time of program entry.

Criminal History

Individuals participating in these demonstration projects not only have a serious mental illness but also have come in contact with the criminal justice system – in many cases, as a direct result of behavior(s) associated with their mental illness. Since the primary goal of this program is to determine effective strategies for curbing recidivism among this population, criminal history is an important aspect of this profile.

Age at First Arrest: The age of first arrest ranges from 7 to 62 years. The average (mean) age at which a participant was first arrested is 24 years, and the median age (that above and below which one half of the cases appears) is 21 years.

Jail Bookings: The mean number of bookings for participants during the 36 months preceding the program entry is 4.3, and the median is 3 bookings. In five cases, the number of bookings was between 32 and 67.

Number of Convictions: The mean number of convictions during the 36 months prior to the qualifying arrest is approximately 2. Further, between 16.6 and 20.2 percent of participants had four or more convictions during the three years prior to entry into the program.

Type of Convictions: The three most prevalent types of convictions for participants during the 36 months prior to entering the program were drug offenses (between 25.4 and 26.8 percent); misdemeanors other than property or drug offenses, many of which are characterized by law enforcement as nuisance crimes (23.3 to 24.6 percent); and property offenses (between 19.0 and 20.4 percent).

Days in Jail Prior to Program: When there is a heavily skewed distribution of data, the median (the number above and below which one half of the cases appear) is a better measure of central tendency than the mean.

The data reported for this variable indicate that five individuals spent more than 720 days in jail during the 36 months prior to program entry. Expressed as a median, the average number of days participants were in jail during the 36 months prior to program entry is approximately 54 days.

Days in Jail for Qualifying Arrest: Participants spent an average (mean) of between 82 and 88 days in jail for the arrest that qualified them for program participation. The median number of days was 60, and this may be taken as a more appropriate measure due to the skewed distribution of this variable. The number of jail days ranges from 0 to 567.

The Board's researchers anticipate that there will be sufficient data by the next annual report to provide a preliminary analysis of the overall effectiveness of the various interventions that counties have implemented in achieving specific outcomes – e.g., a reduction in bookings and jail days among participants.

Local Evaluations: In addition to collecting and reporting common data elements for the Board's statewide evaluation of this program, counties are using locally developed research designs to test specific hypotheses related to their projects. Counties must submit a Final Project Evaluation Report to the Board within 90 calendar days of the contract ending date (June 30, 2003).

These evaluations, which provide counties an opportunity to focus on unique aspects of their project, must include sufficient information about the participants, research design, nature and extent of treatment interventions, and data analysis procedures to permit replication of the program by others.

The counties' reports must also include a process evaluation focusing on how the program operated rather than the results it produced. In addition, most counties will conduct some type of cost benefit analysis as part of their local evaluation.

By the end of the grant period, the findings from each grantee's local research, coupled with the Board's evaluation of the overall effectiveness of these demonstration projects, should provide much-needed insight on what works in curbing recidivism among mentally ill offenders.

PROGRAM EXPANSION

The 2000/01 Budget Act includes a $50 million appropriation to expand the Mentally Ill Offender Crime Reduction Grant Program. Of this amount, the Budget stipulates that up to $2 million be awarded to counties for non-competitive planning grants and the remainder, less the Board's administrative costs, be used to support additional demonstration projects.

In August 2000, the Board received planning grant applications from 25 counties and, in September, awarded funds to all applicants to assist them in developing or updating a local plan outlining existing services, gaps in the present continuum of responses to mentally ill offenders, and prioritized needs.

As is its longstanding practice, the Board established an Executive Steering Committee (ESC) to develop the content, format and requirements of the Request for Proposal application as well as the proposal evaluation criteria and weight associated with each rating category; to evaluate and rank proposals; and to make award recommendations to the Board (see Appendix F – FY 2000/01 ESC Members). In April 2001, following an extensive review of 23 proposed projects submitted by counties in March 2001, the ESC recommended that the following counties be awarded available funds (approximately $47 million).

County	Award
Ventura	$2,460,546
Yolo	$2,704,541
San Joaquin	$4,175,327
Marin	$4,244,626
Monterey	$2,607,022
San Francisco	$3,488,400
Butte	$2,877,498
Tuolumne	$ 833,209
Mendocino	$1,987,526
Alameda	$5,000,000
Los Angeles	$5,000,000
San Bernardino	$4,408,318
Solano	$4,978,822
Kern	$1,961,796

At its May 17 meeting, the Board approved the recommendations and awarded 14 grants (see Appendix G – Overview of New Grant Awards) that will take effect on July 1, 2001 and expire, unless extended, in three years.

The Board's researchers will use the same evaluation design in assessing the efficacy of these new projects in curbing recidivism among mentally ill offenders – i.e., the collection and analysis of common data elements.

The Board's next annual report on the Mentally Ill Offender Crime Reduction Grant Program will include detailed information on the FY 2000/01 grants.

APPENDIX A

BILL NUMBER: SB 1485 CHAPTERED

CHAPTER 501

FILED WITH SECRETARY OF STATE SEPTEMBER 15, 1998

APPROVED BY GOVERNOR SEPTEMBER 15, 1998

PASSED THE SENATE AUGUST 30, 1998

PASSED THE ASSEMBLY AUGUST 27, 1998

AMENDED IN ASSEMBLY AUGUST 21, 1998

AMENDED IN ASSEMBLY JULY 8, 1998

AMENDED IN SENATE MAY 5, 1998

AMENDED IN SENATE APRIL 1, 1998

INTRODUCED BY Senator Rosenthal

(Principal coauthor: Senator Rainey)

(Coauthor: Senator McPherson)

(Coauthors: Assembly Members Hertzberg, Migden, Papan, Strom-Martin, Sweeney, and Thomson)

FEBRUARY 4, 1998

An act to add and repeal Article 4 (commencing with Section 6045) of Chapter 5 of Title 7 of Part 3 of the Penal Code, relating to mentally ill criminal offenders.

LEGISLATIVE COUNSEL'S DIGEST

SB 1485, Rosenthal. Mentally ill offender crime reduction grants.

Under existing law, it is the duty of the Board of Corrections to make a study of the entire subject of crime, with particular reference to conditions in the State of California, including causes of crime, possible methods of prevention of crime, methods of detection of crime, and apprehension of criminals, methods of prosecution of persons accused of crime, and the entire subject of penology, including standards and training for correctional personnel, and to report its findings, its conclusions and recommendations to the Governor and the Legislature as required.

This bill would require, until January 1, 2005, the Board of Corrections to administer and award mentally ill offender crime reduction grants on a competitive basis to counties that expand or establish a continuum of swift, certain, and graduated responses to reduce crime and criminal justice costs related to mentally ill offenders. The bill would require the board, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, to create an evaluation design for the grant program that will assess the effectiveness of the program in reducing crime, the number of early releases due to jail overcrowding, and local criminal justice costs, and would require the board to submit annual reports to the Legislature based on the evaluation design. The bill would require funding for the program to be provided, upon appropriation by the Legislature, in the annual Budget Act.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) County jail inmate populations nearly doubled between 1984 and 1996, from 43,000 to 72,000. Court-ordered population caps have affected 25 counties and represent 70 percent of the average daily population in county jails. As a result of these caps and a lack of bed space, more than 275,000 inmates had their jail time eliminated or reduced in 1997.

(b) An estimated 7 to 15 percent of county jail inmates are seriously mentally ill. Although an estimated forty million dollars ($40,000,000) per year is spent by counties on mental health treatment within the institution, and that figure is rising rapidly, there are few treatment and intervention resources available to prevent recidivism after mentally ill offenders are released into the community. This leads to a cycle of rearrest and reincarceration, contributing to jail overcrowding and early releases, and often culminates in state prison commitments.

(c) The Pacific Research Institute estimates that annual criminal justice and law enforcement expenditures for persons with serious mental illnesses were between one billion two hundred million dollars ($1,200,000,000) and one billion eight hundred million dollars ($1,800,000,000) in 1993-94. The state cost in 1996-97 to incarcerate and provide mental health treatment to a seriously mentally ill state prisoner is between twenty-one thousand nine hundred seventy-eight dollars ($21,978) and thirty thousand six hundred ninety-eight dollars ($30,698) per year. Estimates of the state prison population with mental illness ranges from 8 to 20 percent.

(d) According to a 1993 study by state mental health directors, the average estimated cost to provide comprehensive mental health treatment to a severely mentally ill person is seven thousand dollars ($7,000) per year, of which the state and county cost is four thousand dollars ($4,000) per year. The 1996 cost for integrated
mental health services for persons most difficult to treat averages between fifteen thousand dollars ($15,000) and twenty thousand dollars ($20,000) per year, of which the state and county costs are between nine thousand dollars ($9,000) and twelve thousand dollars ($12,000) per person.

(e) A 1997 study by the State Department of Mental Health of 3,000 seriously mentally ill persons found that less than 2 percent of the persons receiving regular treatment were arrested in the previous six months, indicating that crimes and offenses are caused by those not receiving treatment. Another study of 85 persons with serious mental illness in the Los Angeles County Jail found that only three of the persons were under conservatorship at the time of their arrest, and only two had ever received intensive treatment. Another study of 500 mentally ill persons charged with crimes in San Francisco found that 94 percent were not receiving mental health treatment at the time the crimes were committed.

(f) Research indicates that a continuum of responses for mentally ill offenders that includes prevention, intervention, and incarceration can reduce crime, jail overcrowding, and criminal justice costs.

(g) Therefore, it is the intent of the Legislature that grants shall be provided to counties that develop and implement a comprehensive, cost-effective plan to reduce the rate of crime and offenses committed by persons with serious mental illness, as well as reduce jail overcrowding and local criminal justice costs related to
mentally ill offenders.

SEC. 2. Article 4 (commencing with Section 6045) is added to Chapter 5 of Title 7 of Part 3 of the Penal Code, to read:

Article 4. Mentally Ill Offender Crime Reduction Grants

6045. The Board of Corrections shall administer and award mentally ill offender crime reduction grants on a competitive basis to counties that expand or establish a continuum of swift, certain, and graduated responses to reduce crime and criminal justice costs related to mentally ill offenders, as defined in paragraph (1) of subdivision (b) and subdivision (c) of Section 5600.3 of the Welfare and Institutions Code.

6045.2. (a) To be eligible for a grant, each county shall establish a strategy committee that shall include, at a minimum, the sheriff or director of the county department of corrections in a county where the sheriff is not in charge of administering the county jail system, who shall chair the committee, representatives from other local law enforcement agencies, the chief probation officer, the county mental health director, a superior court judge, a client of a mental health treatment facility, and representatives from organizations

that can provide, or have provided, treatment or stability, including income, housing, and caretaking, for persons with mental illnesses.

(b) The committee shall develop a comprehensive plan for providing a cost-effective continuum of graduated responses, including prevention, intervention, and incarceration, for mentally ill offenders. Strategies for prevention and intervention shall include,but are not limited to, both of the following:

(1) Mental health or substance abuse treatment for mentally ill offenders who have been released from law enforcement custody.

(2) The establishment of long-term stability for mentally ill offenders who have been released from law enforcement custody, including a stable source of income, a safe and decent residence, and a conservator or caretaker.

(c) The plan shall include the identification of specific outcome and performance measures and a plan for annual reporting that will allow the Board of Corrections to evaluate, at a minimum, the effectiveness of the strategies in reducing:

(1) Crime and offenses committed by mentally ill offenders.

(2) Criminal justice costs related to mentally ill offenders.

6045.4. The Board of Corrections, in consultation with the State Department of Mental Health, and the State Department of Alcohol and Drug Programs, shall award grants that provide funding for four years. Funding shall be used to supplement, rather than supplant, funding for existing programs and shall not be used to facilitate the early release of prisoners or alternatives to incarceration. No grant shall be awarded unless the applicant makes available resources in an amount equal to at least 25 percent of the amount of the grant. Resources may include in-kind contributions from participating agencies. In awarding grants, priority shall be given to those proposals which include additional funding that exceeds 25 percent of the amount of the grant.

6045.6. The Board of Corrections, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, shall establish minimum standards, funding schedules, and procedures for awarding grants, which shall take into consideration, but not be limited to, all of the following:

(a) Percentage of the jail population with severe mental illness.

(b) Demonstrated ability to administer the program.

(c) Demonstrated ability to develop effective responses to provide treatment and stability for persons with severe mental illness.

(d) Demonstrated history of maximizing federal, state, local, and private funding sources.

(e) Likelihood that the program will continue to operate after state grant funding ends.

6045.8. The Board of Corrections, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, shall create an evaluation design for mentally ill offender crime reduction grants that will assess the effectiveness of the program in reducing crime, the number of early releases due to jail overcrowding, and local criminal justice costs. Commencing on June 30, 2000, and annually thereafter, the board shall submit a report to the Legislature based on the evaluation design, with a final report due on December 31, 2004.

6045.9. This article shall remain in effect only until January 1, 2005, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2005, deletes or extends that date.

6046. Funding for mentally ill offender crime reduction grants shall be provided, upon appropriation by the Legislature, in the annual Budget Act. It is the intent of the Legislature to appropriate twenty-five million dollars ($25,000,000) for the purposes of Mentally Ill Offender Crime Reduction Grants in the 1999-2000 fiscal year, subject to the availability of funds. Up to 5 percent of the amount appropriated in the budget may be available for the board to administer this program, including technical assistance to counties and the development of an evaluation component.

APPENDIX B

EXECUTIVE STEERING COMMITTEE FOR MIOCRG I

BOC Members

Harry Nabors, Chairperson
Jerry Krans, Co-Chairperson
Susan Saxe-Clifford, Ph.D.
Daniel Ballin

California State Association of Counties Representative

Supervisor John Flynn, Ventura County

California State Sheriffs Association (CSSA) Representatives

Sheriff Bill Kolender, San Diego County
Captain Norm Hurst, San Bernardino County, CSSA Detentions and Corrections Subcommittee

State Department of Mental Health Representative

Gary Pettigrew, Deputy Director

State Department of Alcohol and Drug Programs Representative

Susan Nisenbaum, Deputy Director

California Mental Health Directors Association Representative

John Anderson, MFCC, Deputy Director, Humboldt County Mental Health Department

APPENDIX C

EXECUTIVE STEERING COMMITTEE FOR MIOCRG II

BOC Members

Chief Taylor Moorehead, Los Angeles County (Chairperson)
Sheriff Lou Blanas, Sacramento County (Co-Chairperson)

California State Association of Counties Representative

Supervisor John Flynn, Ventura County

California State Sheriffs Association (CSSA) Representatives

Sheriff Keith Royal, Nevada County
Chief Norm Hurst, San Bernardino County, CSSA Detentions and Corrections Subcommittee

Chief Probation Officers of California

Chief Melton Losoya, Yolo County

State Department of Mental Health Representative

Tom Wilson
State Department of Alcohol and Drug Programs Representative

Patricia Hill

California Mental Health Directors Association Representative

John Anderson, MFCC, Deputy Director, Humboldt County Mental Health Department

APPENDIX D

COUNTY	CLIENT ELIGIBILITY CRITERIA (CRIMINAL JUSTICE & MENTAL HEALTH)
Humboldt	All inmates, either on or subject to receiving supervised probation conditions when sentenced, and without regard to criminal offense, who are diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or a major depressive disorder.
Kern	Misdemeanants and felony probationers who are seriously and persistently mentally ill and whose functional impairments due to their mental illness place them at risk of harm or homelessness.
Los Angeles	Inmates with two previous arrests and a current arrest for a felony who have a major psychiatric disorder (excluding adjustment disorders), co-existing substance abuse disorder, history of previous psychiatric hospitalization and/or treatment with a major psychoactive medication. Must be homeless or at risk of being homeless and pose no significant risk of danger to the community.
Orange	All offenders who are diagnosed with schizophrenia, bipolar disorder, major depression or psychotic disorders except violent felons such as child molesters, rapists, arsonists and attempted murderers. Offenders who are on probation must receive a minimum of one-year formal probation to be eligible for the program. .
Placer	No specific crimes or diagnosis are excluded. Criminal justice history will be evaluated on a case by case basis.
Riverside	All offenders with a current misdemeanor or non-serious felony offense, and a minimal history of violent or sex offenses, who will receive a minimum nine month sentence. All DSM IV mental illnesses or dual diagnoses except psychosis are included.
Sacramento	Offenders with three arrests and at least one Jail Psychiatric Services admission within a three-year period prior to identification; a DSM-IV diagnosis of schizophrenia or other psychotic disorders, major depression, or bipolar disorder; not on current parole; and no history of violent felonies.
San Bernardino	All inmates with a serious, persistent mental disorder. Inmates with less severe metal disorders but have impairment of functioning will be considered; treatment resistant offenders willing to accept mental health treatment as part of the terms and conditions of parole.
San Diego	Re-offending probationers, except those arrested for offenses with mandatory state prison terms, who have GAF scores below 50 and an Axis I psychiatric diagnosis.
San Francisco	Inmates charged with a felony (excluding murder, arson, child sexual assaults, forcible sex offenses, firearms use, and great bodily injury) with two prior bookings since 1993; and mentally ill offenders on state parole. Axis I disorders (excluding adjustment and substance abuse disorders without co-occurring disorders) or Axis II disorders of paranoid personality disorder, borderline personality disorder, schizotypal or schizoid personality disorder.
San Mateo	Inmates with a history of prior offenses and a DSM -IV Axis I diagnosis.
Santa Barbara	Offenders whose current charge does not involve a serious act of violence, who have one prior booking into jail or juvenile hall, and who are diagnosed with a serious and persistent mental illness with a DSM-IV Axis I diagnosis.
Santa Cruz	Persons with a persistent and serious mental illness who have at least two bookings in the three years prior to entry into the potential client pool.

Sonoma	Seriously mentally ill offenders with a history of two bookings and two mental health system contacts over the last 3 years (priority 1); two or more prior bookings and one psychiatric hospital admission (or open adult services case) over the last 3 years (priority 2); first-time offenders considered psychiatrically unstable with a high potential for recidivism (priority 3).
Stanislaus	All offenders, except those charged with a serious or violent offense or third strike candidates, who have a DSM-IV Axis I disorder.

APPENDIX E

HUMBOLDT COUNTY

MIOCR (More Intensive Options and Creative Responses) Program

Case #1: Client A, a 57-year-old male diagnosed with schizophrenia, has been determined by the court to be mentally incompetent. His suspended criminal charges include trespassing, public intoxication, and failing to register as a sex offender.

This client began interfacing with the criminal justice system at the age of 14, and has been arrested more than 50 times for a wide variety of crimes ranging from misdemeanor theft, intoxication and a sex offense, to felony weapons, drugs and violence.

Client A is intelligent and received a bachelor's degree in mechanical engineering. After working two years in that field, he was unable to manage the stress and became homeless. The client was married for two years at one point, then divorced as symptoms increased again. Mental health services were sporadic, and the client has a vague recollection of interventions dating back to elementary school. Medication compliance has been a major issue, and reliance on alcohol has been steady during times when medication has not been under control. For 30 years he drifted from place to place, at times being hospitalized at the local and state level in residential care.

Once in the MIOCR program, the client was released from custody to independent living housing while not yet fully stabilized on his medication nor committed to taking it. Within a week he was back in custody for public intoxication, then released, and very soon thereafter taken to the psychiatric hospital by local police.

The medication became a more focused issue for the treatment team, and an intensive plan was put into action upon the client's release back to the community. This initially included program staff going to his residence twice daily to ensure medication compliance and living stabilization. The client responded positively to staff, and appreciated the attention and commitment.

He meets twice weekly with the clinician to "have coffee," continues individual sessions with the substance abuse counselor, and receives transportation assistance from the case manager. This continuous outreach from the MIOCR Team has made a positive difference. Therapeutic sessions have brought out an understanding by the client that he has lost the past 30 years of his life due to his mental illness issues, rather than his previous belief that he threw away a promising future.

The client has steadily progressed for four months. He is functioning within the community, has done volunteer work at the Food Bank, and is doing well with medication compliance. He has explored interests in sketching, literature, and spirituality. He has sought out medical care and manages his own medications and appointments at this point with transportation assistance from the case manager. He has not used drugs or alcohol since being medication compliant, and has not had any law enforcement contacts. He has attended the program's twice-monthly therapeutic MIOCR Court. He is considering a part-time job and/or returning to school, although scared and unfamiliar with this new lifestyle.

Case #2: Client B is a 39-year-old male diagnosed as bipolar with co-occurring heroin and alcohol abuse. His current criminal charge is violation of probation, stemming from a previous felony conviction of providing a place for distribution of controlled substances.

The client had his first of ten arrests at the age of 21. Arrests have primarily involved felony drug and theft charges.

He reports that his mother died when he was 7 years old. He was removed from his biological father's custody at age 12 due to abuse. He was placed in a foster home where alcohol became a problem and the foster parents divorced. He married before age 20 to a girl in her mid-teens, and they divorced about 1994. They have three children, ages 7 to 16.

The client began decompensating after a major accident that left him disabled with back injuries. His first interface with the mental health system was at the age of 29 with a first diagnosis of intermittent explosive disorder and alcohol abuse. Interventions were crisis oriented. During his divorce and custody battle, he began long-term treatment with a local private psychiatrist. He was diagnosed with bipolar disorder and began medication. He has continued to see this psychiatrist. Since his divorce he made one suicide attempt and has had several contacts with the legal system. He has had difficulty with medication management, involving both psychiatric and pain medications.

Once enrolled in the MIOCR Program, interventions began in custody over a period of 69 days with the team clinician and substance abuse counselor, which included both group and individual sessions. The client then transitioned to community living in a clean and sober house over four months ago. He has maintained sobriety and has been free of contact with the criminal justice system other than those imposed by the program -- twice-monthly therapeutic MIOCR Court sessions and intensive probation supervision. The group and individual sessions have continued. The case manager's work with him includes his ongoing challenge of money management. With the help of the probation officer, the client has worked for modification of visitation and now has weekly supervised visitation with his children. The client initiated contact with the community college and is currently taking classes. He has taken on a leadership role with the other MIOCR clients, and serves on the Client Representative Team in meetings with the MIOCR staff.

The assistance the MIOCR Team has offered with a wraparound approach to coordination of services and support has helped this client believe that he has a voice, that the team really listens to his needs, and that he has the ability to make choices and positive changes.

KERN COUNTY

JAILink (Jail Alternatives, Information and Linkage) Program

Case #1: PL is a 24-year-old Hispanic man with an eighth-grade education. His mental illness-related problems began three years ago after a tree-trimming accident affecting his lower back and liver rendered him unable to work without severe pain. His primary diagnosis is major depressive disorder, recurrent, severe, with psychotic features. His secondary diagnosis is schizophrenia, paranoid type. PL lives in an apartment with his wife and two children. PL abuses alcohol and, when under the influence, he becomes violent and threatens to beat up or kill people. His mother has always been responsible for administering his medications.

PL has become very enmeshed with several relatives who live in the same complex and act as co-dependent enablers for him. For example, during a recent public intoxication incident, family members found him and took him home "so he wouldn't get arrested." Shortly afterwards, he left the rehab center where he was receiving treatment. His wife picked him up and brought him home, where PL resumed drinking and threatening his family. Rather than calling the police, they took him to the County Medical Center, where he again entered rehab. This was PL's third time in a rehab program; the longest he had ever stayed was three weeks.

PL was ordered into the JAILink program after attacking a security officer at Kern County Medical Center who pressed assault charges. The JAILink caseworker returned him to his rehab outpatient team, where he had been receiving counseling and services for anger management. Because of PL's prior non-compliance with treatment, the JAILink caseworker-probation officer team began conducting periodic home visits.

After two months in the program and in outpatient treatment, the JAILink team received a call about PL showing up drunk for a substance abuse counseling session and making advances toward a female group member. Unfortunately, PL's probation orders did not include a prohibition against drinking alcohol. Still, during their next home visit, the team probation officer warned PL that he could face a jail term if the incident is repeated. A month later, while at the market with his five-year-old daughter, PL took a can of beer off the shelf, drank it in the presence of the store manager without paying for it, and locked himself in the bathroom. After the manager called the family, they paid for the beer and brought PL and the child home. Several days later, several family members called the JAILink caseworker to report that PL was "out of control." They had not called the police: "We don't want him to get in trouble."

Because rehab seemed not to be working, the JAILink team invited PL, his wife, and another family member to the JAILink office to talk about treatment options. Among the options discussed (but not exercised) was a 15- to 30-day drying-out period in jail. During this meeting the JAILink team discovered that PL is currently serving felony probation for spousal abuse and growing marijuana in a neighboring county to which he travels once a month for a court appearance.

After two months and no incidents reported to the JAILink office, the team made a home visit. PL's wife reported that four days previously, while drunk, PL had threatened to cut her up with a chain saw during one of his blackouts. Rather than calling the police or the JAILink team, she took PL to an inpatient program. At that point in this conversation, PL arrived home, having walked out of his current program. The exasperated family members asked the JAILink team to "do something about him."

The team arranged a PACT (Provider Authorization/Coordinating Team) meeting, which was attended by family members and representatives from JAILink and the rehab program. Although PL refused the suggestion that he petition the court to add drugs and alcohol to his probation orders, he accepted the option to enter a structured 12-month court-directed forensics program. During the month-long waiting period for the program, PL got drunk again and terrorized his family. When confronted by JAILink team members, PL said he realized that his wife had reached her limit. He admitted, "I'm going to hurt someone or myself," and finally agreed to enter the inpatient program with the understanding that, if he leaves, he will have to go to jail.

PL appeared for his court hearing and is currently awaiting entry into the inpatient program. In the interim, JAILink team members have received no reports of law violation for PL and have not been contacted by his family.

Case #2: JH, an 18-year-old Caucasian male, was characterized by his JAILink program caseworker as a "self-imposed failure." From the beginning of his involvement with the program, JH has been evasive and hesitant to cooperate. His family background is troubled. JH knows the identity of his biological mother, but because she abandoned him as a young child, he has had little contact with her. His adoptive parents are now divorced; the mother is a drug addict. JH currently lives in a rural community with the adoptive father, a 65-year-old alcoholic who holds extremely racist views. JH has learned these ideologies from his adoptive father.

JH's original conviction was for tagging (writing graffiti) on bridge abutments in Bakersfield. A psychology technician in the county jail provided an initial diagnosis of major depressive disorder. Later, a psychiatrist provided a diagnosis of psychotic disorder and alcohol abuse. JH began taking medications and was directed into a treatment program. After only a few days in the program, however, JH was caught tagging again by the same officer who had previously arrested him. He was jailed for a short period, went to court, was bailed out, and resumed living with his father.

When the JAILink caseworker investigated the client's criminal history, he discovered that JH had been booked as a juvenile on tagging and assault with a deadly weapon on his former girlfriend and that he is still on juvenile probation. He also learned that JH had been sent to Boys' Ranch. At that time, there was no mention of psychological difficulties or mental illness from earlier reports. JH was characterized as a good student and a "normal kid."

Within a few days of the tagging case that resulted in his assignment to JAILink, JH assaulted the same young woman, "going crazy" and pulling a knife, when she told him she was no longer his girlfriend. JH was then taken back in custody and charged with a felony. The District Attorney dismissed the charge of assault with a deadly weapon but proceeded with a probation violation based on the facts underlying the dismissed case, provided primarily by his former girlfriend's testimony. JH was convicted and sentenced to 30 days in jail.

After completion of jail time, JH was transported directly to the JAILink office to start JAILink activities, including a drug treatment program. According to his caseworker, JH had been "doing great," but only for awhile. JH talked extensively with the caseworker, revealing that his father "doesn't trust" his JAILink probation officer—who is African American. After a time, JH even signed a form withdrawing consent for his JAILink caseworker and probation officer to talk to his parents, now claiming that the JAILink team "can't be trusted."

JH stayed in the drug program for a little less than a month. He was released after a staff member found him smoking marijuana one night, which is against program rules. JH's father was called to pick him up. However, JH was reported to have run away before his father arrived. The next day, the JAILink probation officer and caseworker went to the father's apartment to inquire about JH. His father stepped outside and quickly shut the door behind him. When the JAILink team asked about JH, the father replied that "the niggers ran him out of the program." The JAILink team proceeded to inform him that this was not the fact; this is not how it happened. They suspected that JH was behind the door during the conversation. The JAILink team then proceeded to obtain a warrant for JH's arrest, but they were unable to locate him.

After a time, JH broke into the room where his former girlfriend was sleeping. He jumped on the bed and began beating her, saying repeatedly, "I'm going to kill you." He choked her until she lost consciousness. When she regained consciousness, she ran out to a business across the street and called the police. JH was caught hiding in the bushes nearby.

JH is now in custody. He will be sentenced 12/15/00. He negotiated a plea agreement and pled guilty to assault with a deadly weapon on the condition that he spend no more than two years in state prison. He could end up on felony probation, but this is not likely. If so, he would remain eligible for JAILink. On January 3, 2001, the Court determined that JH was no longer a suitable candidate for probation and committed him to State Prison for a term of two years.

LOS ANGELES COUNTY

CROMIO (Community Reintegration of Mentally Ill Offenders)

Case #1: Carl joined the CROMIO program while serving a year jail sentence for assault with a deadly weapon. Enraged over his girlfriend's infidelity, he chased his rival with a crowbar, threatening to kill him. Instead, he smashed the rival's car with the crowbar, damaging it. As a result, he was sentenced to a year in jail, 3 years formal probation and a mandate to complete an Anger Management program.

Carl's legal record includes 2 prior felony convictions, each in New Jersey for terrorist threats and possession of a controlled substance. He violated probation on both convictions by not reporting and fled New Jersey to avoid re-arrest and possible incarceration in state prison. He arrived in California at age 23 and joined a Venice Beach gang, became involved with an alcoholic female, and started using cocaine.

Carl has a long history of child abuse, substance abuse, mental illness and nearly continuous incarceration since age 11. Family history reveals that he is the sole adopted child of alcoholic parents who divorced when he was a child. His stepfather was physically abusive and his mother, who passively witnessed the physical abuse, was verbally abusive. As a child, Carl was diagnosed with ADHD and prescribed Mellaril. He was a constant behavior problem, frequently getting into fights that resulted in expulsion from numerous juvenile programs. While in a juvenile residential program, he was raped. Prior psychiatric diagnoses include Depression and Substance Induced Psychosis. Currently, his diagnoses are Bipolar I and Polysubstance Abuse. His psychotropic medications are Risperdal, Prozac, Lithium and Trazadone.

CROMIO treatment began in July 2000 when his Personal Service Coordinator (PSC) initiated meeting with him once or twice a week while he was in jail. Carl set a short-term goal to complete a residential substance abuse program that would assist him in maintaining his sobriety. His long-term goals included obtaining a GED, a plumber's license and an apartment. He was motivated by fear of being re-arrested and possibly spending his life in state prison and the despair of "having nothing in life at age 25".

When released from jail, Carl was housed temporarily in a shelter followed by placement in a residential drug rehabilitation program. He experienced some difficulty following the program rules but managed to complete the first of seven treatment phases. In the initial phase, residents are confined to the facility and cannot make calls. At the end of this period, they take a written test and present their treatment goals to their counselors and their peers. Carl completed these tasks. He appeared to be adjusted to and comfortable with the program; however, five days after completing phase one, he was discharged because he confronted staff and initiated a racially oriented clique among his peers. Remorseful and full of self-blame, Carl then entered a 30-day transition house to stabilize and reassess his goals. He also began individual counseling with a team social worker focusing on developing self-esteem and managing his anger. Despite occasional confrontational behavior with the transition house staff, Carl completed the 30-day period maintaining his sobriety. He amended his goals to include outpatient (rather than inpatient) substance abuse treatment with a strong emphasis on gaining employment.

Currently, Carl resides at a shelter. At one point he stopped eating and refused his medications for four days because he was feeling depressed and was discouraged about the long waiting time for a new placement. His PSC, in collaboration with the shelter staff, provided counseling, support, encouragement and structure that helped him through this difficult period. To date, he is progressing in anger management treatment, had caps placed on two front teeth, noticeably increasing his self-esteem, made efforts to find temporary employment, and maintained sobriety. Reunification with his mother appears possible.

Case #2: Sam is a 40-year-old married white male with a diagnosis of Bipolar Disorder with Psychotic Features. He also has an extensive history of substance abuse, primarily crack, since age 10. His most recent arrest that occurred in June 2000 was for possession of crack cocaine. In 1996 he was arrested for robbery. He has never been in state prison. Currently, he is on probation for four years and has been court ordered to participate in CROMIO as well as in one year of residential chemical dependency treatment.

Sam first met his Personal Service Coordinator in September 2000 while housed in Twin Towers Correctional Facility of Los Angeles County Jail. Because of his court order, Sam's release plan was placement in a long-term

residential substance abuse facility. Upon his release from jail in October 2000, he was placed in such a program that addresses both his mental illness and his substance abuse. In the previous 18 months, he had attended another residential substance abuse treatment program but it did not have a mental health treatment component. He completed the program, receiving maximum benefit though he did not appear highly invested in behavior change, with the result that he made limited progress.

After his release from jail, Sam was initially very cooperative and appeared highly motivated to change his behavior. A month later, he became increasingly resistant and disruptive to the program. He did not complete his assigned chores and engaged in behaviors that irritated others. He seemed to behave in a way to ensure expulsion from the program, hoping that his Personal Service Coordinator would place him in another program closer to his wife. The client reported that his wife was severely mentally ill and had not been receiving regular mental health care since his arrest. He had always taken care of her. In addition, she was about to be evicted from their apartment because of nonpayment of rent. Sam lost his SSDI due to his incarceration in jail and his wife's SSI check alone was insufficient to meet her expenses. His wife's mental illness and inconsistent treatment, her continued substance abuse, and his guilt over introducing his wife to drugs and their possible eviction from their apartment contributed to his distress. His Personal Service Coordinator and his Probation Officer worked with the client on these issues that were causing him to lose focus in the program.

Sam's Personal Service Coordinator contacted an outpatient mental health agency near the client's apartment and arranged for his wife to be seen, assisting her in obtaining the psychotropic medications she needed and in avoiding eviction. The Personal Service Coordinator also arranged a half-day pass for Sam to visit his wife. The client was transported to and from the visit by his Personal Service Coordinator to make sure he saw his wife and returned to his treatment program. Unfortunately, Sam's visit with his wife exacerbated his concern about her, because he witnessed her poor condition and observed her drug using friends hanging around the apartment. Sam and his Personal Service Coordinator continue to discuss his wife, her difficulties and how they can work together to assist her in addition to working on his own issues.

The firmness of the Probation Officer, the flexibility of the treatment program and the regular and frequent visits with his Personal Service Coordinator have all served to keep Sam focused and involved in his treatment. The collaboration of Sam's Personal Service Coordinator and his Probation Officer has facilitated his treatment success and ensured that he abides by his court orders.

ORANGE COUNTY

IMPACT (Immediate Mental Health Processing, Assessment, Coordination & Treatment)

Case #1**:** Bao is a 33-year-old single Vietnamese-American male who was arrested and put on probation for residential burglary. He understands and speaks English fluently. Bao was born in South Vietnam, orphaned and adopted by foster parents and came to the U.S. when he was 10 years old. As a child he was unwanted, and lived in one foster home after another. These homes offered little in the way of love and nurturing, and discipline was inconsistent or nonexistent. Bao was regularly beaten and belittled by his foster parents. While a teenager, Bao had symptoms of depression, with a severe lack of self-worth. He lacked focus in his schooling. He attended school until 9th grade at which time he dropped out. He began using drugs and alcohol as a way to cope with his emotional problems and his difficulties in adjusting to life in the U.S. Eventually he became involved in gang activities. At age 14 he was charged with larceny and car theft. At 22, he was arrested for petty theft, possession of forbidden weapons, and racketeering. At the age of 33 he was charged with residential burglary and heroin use.

When IMPACT first interviewed him in jail, Bao appeared weak, pale and underweight. He walked slowly with his head down. He looked depressed, with frequent complaints of headaches and hearing voices. He had poor eye contact and difficulty generating thoughts.

Upon release from jail, IMPACT staff placed Bao in a residential rehabilitation program that specialized in serving consumers who are dually diagnosed. While there he was linked to a County outpatient mental health clinic for medications and currently sees his psychiatrist every month. He is also seen for counseling every week. His IMPACT case manager has maintained contact with him on a regular basis for follow-up and support. It was strongly believed that Bao's involvement in drugs and alcohol was due in part to his background of being abused and neglected as a child. His IMPACT case manager encouraged him to face his negative feelings and helped him understand that his past was strongly linked to his mental illness and drug abuse. Bao began feeling better as he realized the benefits of sharing his emotional pain with someone else.

Bao has made tremendous progress. His IMPACT probation officer, outpatient care coordinator, his therapist, and the residential manager all agree that he is doing well physically and mentally. Though he continues to manifest some anxiety he has been drug-free since his release from jail and no longer complains of hearing voices. He continues to participate in group therapy regularly, and he complies with medication treatment. The group he attends is for Vietnamese-American clients and family members. The program provides intensive treatment and rehabilitation for individuals who are victims of traumatic experiences. Group activity focuses on decreasing the debilitating symptoms of mental illness and reducing the functional impairments of group members. The members are all Vietnamese-American, and a great deal of effort has been made to ensure that the program is sensitive to the Vietnamese culture.

Case #2: Dave is a 34-year-old single male placed on formal probation with Orange County and assigned to the IMPACT Program's enhanced case management and probation services. At the time of being selected for IMPACT, he was serving a sentence for burglary with a prior and for possessing less then an ounce of marijuana. He has a long history of arrests and a history of mental illness since age 13, which has included symptoms of depression with suicidal ideas and attempts. He reports a history of hearing voices, and displaying self-destructive behaviors such as self-inflicted cutting. He also has had a history of severe alcoholism since age 18 and reports drinking so much vodka that he vomited blood. He further admits to use of a wide variety of drugs, including ecstasy, IV heroin, speed, cocaine and marijuana. His current diagnosis is Psychosis NOS, alcohol dependence and polysubstance abuse. While in jail he displayed symptoms of a mood disorder and psychotic symptoms and he attempted suicide by hanging.

Prior to Dave's arrest he was living on the streets. His time was spent panhandling and recycling aluminum cans to collect money each day for food, beer, and cigarettes. He reports that his biggest stress at that time was being homeless and not having money. He was taking Haldol but stopped because of the "intolerable side effects." He was also drinking up to a 12-pack of beer daily. At one point he attempted to stop drinking, which resulted in increased persecutory thinking and a worsening of the voices he was hearing. His use of speed and marijuana also increased his paranoia and grandiose delusions.

With the intervention and support of IMPACT, Dave is presently living in a board and care home. He currently receives medication services and attends weekly group therapy through Alcohol and Drug Abuse Services. He also has an assigned care coordinator at that clinic. In addition, he attends AA/NA meetings at least twice a week. Dave's IMPACT case manager maintains ongoing contact with Dave, usually visiting him at his residence. The case manager also offers consultation to the Board and Care operator when there are issues that arise with Dave. He also sees his IMPACT probation officer frequently and gets urine tested at least once a month. He has had two negative tests and one positive test for use of marijuana. Because of the positive drug testing, a staffing of Dave's case has been scheduled. In keeping with IMPACT's goal to serve consumers through a collaborative effort, staff participating in the meeting will include Board and Care staff, his IMPACT probation officer, primary care coordinator in Alcohol and Drug Abuse Services and IMPACT case manager.

Despite his recent use of drugs, Dave shows a generally pleasant and friendly demeanor, and he shows good adaptability to board and care living. He reports good response from his current psychotropic medications. There have been no debilitating psychotic symptoms or suicide attempts requiring psychiatric hospitalization nor has he engaged in any further criminal activity.

PLACER COUNTY

CCARES (Continuum of Care to Avoid Re-arrest and Enter Society)

Case #1: Luke M. is a 23-year-old Caucasian male who entered the CCARES program October 31, 2000. He was originally arrested on February 10, 1999 for threats of bodily harm - 422 PC a felony- and cutting a utility line penal code 136.1 (b) (1) PC, as an attempt to keep his family members from calling the authorities. At the time of the original offense, he was under the influence of cocaine. Luke's involvement with the criminal justice system between the original arrest and the current violation was very active. Between the two dates he acquired a total of eight violations and one would become a new conviction. The violations included walking away from residential substance abuse treatment programs, testing positive for illicit drugs while in treatment, and committing a new offense, a 261.5 PC, unlawful sex with a minor. By this time, Luke had terminated his treatment at four residential treatment programs, never completing one successfully. He had extinguished all of his options with the County, private providers, and most importantly with probation and the courts. He was facing six years in state prison.

Historically, Luke is the oldest of four adopted children. His biological mother suffered from epilepsy and was medicated throughout the pregnancy. Luke, in his elementary school years, was diagnosed with attention deficit disorder and, when put on Ritalin, he became very violent. This is when oppositional defiant disorder became evident. In the years that followed, Luke was given several diagnoses including Turret syndrome, developmentally disabled, attention deficit with hyperactivity disorder, bi-polar disorder, developmental disorder, psychosis not otherwise specified, adjustment disorder with mixed disturbance of emotions and conduct, and poly-substance abuse with dependence. Currently, he is diagnosed as Bi-polar Type One. During his adolescent years, Luke was placed in group-homes because his behavior was unmanageable at home. It was such behavior that first introduced him to the legal system. Luke would maintain this status into early adulthood moving from juvenile probation to adult probation.

Since entering the CCARES program, Luke has been observed to be responding to the various aspects of treatment that are unique to CCARES. These include intense case management, structured courses, intense residential treatment, and the collaboration between the justice system and mental health. To date, Luke has remained in residential treatment for three months, has over 125 days of sobriety, has maintained visitation with his daughter, is having successful home visits with family, and has not violated probation.

Case #2: Chuck was selected for the CCARES program in November of 2000. This was following his adjudication on charges of 496 PC (receiving stolen property) and 11364 H&S (possession of a smoking device) and two violations of probation that resulted from his failure to complete a mandated substance abuse treatment program and to pass a drug screen.

Chuck was raised in a catastrophic family environment. As a result of his mother's heavy drug use, Chuck was sent at the age of six to live with his grandmother. During the two years he spent with his grandmother, he worried constantly about his mother, his anxiety fueled by his grandmother's references to his mother being "sick". When Chuck was eight he returned to his mother's home where he was exposed to, and forced to participate in, the rampant drug use that was a part of his home environment.

As in many such families, Chuck's home life was also extremely violent. Chuck recounts memories of "a friend of my stepfather who wore army clothes all the time and ran around on the roof with guns". He also recalls, "one guy used to shoot drugs in his tongue and the blood would spurt all over the mirror and he'd make us clean it up". Chuck recalls at the age of eight or nine one of his mother's friends throwing a pot of boiling water on Chuck's brother, who was subsequently hospitalized with severe burns.

In addition to the constant drug abuse and violence he was exposed to, Chuck was also exposed to extensive sexual activity. "Our mom and dad and other people would do it right in front of us," Chuck recalls. He remembers being propositioned by various men in the house and being beaten for resisting their advances. Though instability, abandonment, and violence marred Chuck's childhood and adolescence, the most traumatic event occurred when he

was 19 years old. During that time Chuck and his brother took his mother to a remote area in the mountains to detox her and themselves. Shortly after their arrival, Chuck's mother left, and after searching several days, Chuck found her hanging from a tree, dead. He cut her down and attempted CPR on her decomposing body. This trauma continues to plague his memories and current thought processes. Chuck's current diagnosis is Major depression (recurrent), PostTraumatic Stress Disorder, and Amphetamine Dependence.

Since his arrest, Chuck has been receiving concurrent substance abuse and mental health treatment services. His substance abuse treatment services are provided by one of Placer County's collaborative treatment providers with his mental health treatment, and comprehensive case management, being provided by staff of the CCARES project.

Chuck has been drug free for over eight months, with a good prognosis for full recovery. His mental health issues, although well managed, are still at times troubling for him. He is receiving a great deal of treatment and care with the CCARES medical and clinical staff, including treatment, and intensive case management. He is working in his therapy on these unresolved clinical issues. In addition, Chuck has regular contacts with his case manager and is currently working on an employment and long-term housing plan. The Placer County CCARES program affords Chuck the much-needed resources and intensive services necessary to overcome the many obstacles he faces, and avoid re-arrest and/or relapse.

RIVERSIDE COUNTY

SHADP (Specific Housing and Discharge Planning Unit)

ASP (Alternative Sentencing Program)

Case #1: EK is a 44-year-old African American female with an extensive mental health history. She is single with one child, and has a diagnosis of bipolar disorder with psychotic symptoms and heroin use.

EK has been a mental health consumer for most of her life, starting at age 13. She has been non-compliant with her medication regime in the past, which led to numerous contacts with the criminal justice system and an eventual prison term in 1990. Her drug abuse history began circa age 34. She abused heroin sporadically while trying to function as a "normal" adult. She began to steal from local grocery stores in an effort to support her needs. She was arrested in September of 1999 for Robbery, Assault with a Deadly Weapon, and Petty Theft with a Prior. She began to receive mental health services at Robert Presley Detention Center and remained cooperative with the mental health services. She realized she needs substance abuse treatment in conjunction with mental health services to help improve her ability to function in the community.

This client received formal probation in March 1999 and was randomly chosen to participate in the Alternative Sentencing program. (ASP) She was interviewed by the ASP psychiatric social worker and disclosed she had attended college and worked as a medical assistant. EK has also entered 23 drug treatment programs that proved beneficial for short periods of time. She was able to abstain from drug use, for at least one year, and twice in her life. She was given the terms and conditions of the program, agreed to participate and was released to the ASP in March 2000.

The ASP was able to offer EK a variety of services. She participated in individual therapy, group therapy, substance abuse classes, occupational therapy, anger management, and parenting classes daily. She began her community reintegration portion of the program after seven months. She attended classes offered by Jefferson Wellness Center, a community day treatment center, once a week and attended ASP the remaining days.

EK has not failed drug testing and continues to remain drug free. She expressed interest in returning to college. The team was able to assist her in enrolling in college classes. She graduated from ASP in November 2000. She has remained drug free, medication compliant, and still attends college. She maintains a relationship with the ASP team members and periodically returns to update the staff on her progress. EK will continue to receive intensive probation services until March 2003.

Case #2: SG is a 22-year-old African American male who has never been married and has no children. SG is diagnosed as having a psychotic disorder and marijuana drug abuse. He was placed on formal probation in October 1997 for Robbery, Assault with a Deadly Weapon, Burglary, and Grand Theft, and was re-arrested on a Violation of Probation in November 1999.

SG was randomly chosen to be housed on the Specific Housing and Discharge Planning Unit (SHADP) at the Robert Presley Detention Center. SG initially denied participation in criminal activity, past or present, and did not believe he had mental health issues. He believed, as did his mother, that his behavior might be the results of a thyroid disorder. There is a family history for thyroid disorders and SG believed he displayed many of the symptoms associated with thyroid problems. Despite his beliefs, the client remained cooperative with staff and eventually began to accept his disorder.
SG had a July 2000 release date. He was able to receive aggressive discharge planning prior to his release date. He was interviewed by the MIOCR mental health worker, who determined that SG had problems in many areas of his life (i.e., religious, financial, mental health, educational, and legal issues).

The SHADP mental health worker was able to link this client to mental health services so he would have continuous mental health counseling, case management services, medication, and medication management. SG received a two-week supply of medication subsequent to his release from jail. He was transported to an intake appointment by his probation officer and then to the mental health homeless program, where he was able to obtain clothing. His

probation officer then drove him to his home. SG continued to receive intensive probation services that included random drug testing.

SG completed probation in January 2001. During his commitment, he was able to deal with his religious issues. He kept all of his mental health appointments and remained medication compliant. He enrolled in barbering school and currently works under apprenticeship in a barbershop. SG is still trying to obtain his social security benefits. He has not had any negative law enforcement contacts and has discontinued his use of alcohol and marijuana. He has successfully won the trust of his family and has a special friend who acts as his sponsor. SG plans to move to Atlanta to pursue educational and employment opportunities.

SACRAMENTO COUNTY

Project Redirection

Case #1: Ms. E is a 27-year-old African-American female with a dual diagnosis of Bipolar Disorder and Drug Dependence (crack cocaine.) She has at least a five-year history of involvement with the criminal justice system with arrests and incarcerations related to drug use, prostitution, and probation violation. In the three years prior to her admission to Project Redirection, she had a total of six arrests that accounted for 128 jail days. She had not been treated for her Bipolar Disorder prior to her involvement with Project Redirection. Her admission date to the program was May 2000.

Ms. E's family history is positive for drug and alcohol use and mental illness. She began her drug use at age 14, dropped out of high school in the tenth grade due to pregnancy and was a single parent by age 18. She began a cycle of homelessness, prostitution, arrests and incarceration starting at age 22. At the time of program admission, she was estranged from her family. She has not had contact with her nine-year old daughter in four years. The child lives with her legal guardians, Ms. E's aunt and uncle. A second child, born two years ago with positive toxicology screens, was removed from Ms. E's custody at birth and relinquished for adoption.

The client's agreement to participate in Project Redirection stemmed from a strong desire for a life style change that included one of sobriety. She expressed ambivalence about the involvement of the probation officer in her treatment yet accepted the terms identified by the project's probation officer (weekly meetings and random urinalysis.) Her experience with law enforcement was negative as she perceived all law enforcement as the enemy.

Upon release from jail she was met by her case manager and admitted to the project's short-term residence, Southside House. A comprehensive treatment plan was soon developed that addressed her psychiatric, substance abuse, and life-skills needs. In conjunction with Sacramento County's Alcohol and Drug Bureau, she was admitted to an intensive, highly structured drug and alcohol day treatment program for 60 days. She successfully graduated. Her case manager provided support and consultation to the day treatment staff regarding her mental health issues and challenges. With the exception of a one-day relapse on her birthday (alcohol), she has been clean and sober since her program involvement.

Her commitment to sobriety is strong. She frequently and regularly attends her NA/AA groups, meets weekly with her sponsor and actively requests random drug testing to help maintain her sobriety. She no longer prostitutes to support her habit. Her view of law enforcement has changed. They are no longer the enemy and are viewed as a significant support to her recovery.

She sees her psychiatrist regularly. She has become knowledgeable about her mental illness as well as the importance of taking her psychotropic medication. She has learned money management skills and does volunteer work as a clerical assistant.

Vocation and education goals are the next step for Ms. E. Through the assistance and advocacy of her case manager, she obtained SSI benefits as well as subsidized housing. She lives independently and continues to develop life skills, i.e. money management, delayed gratification. She has made contact with her family and visited with her daughter for the first time in four years this past Christmas. Ms. E's current goals are 1) to reunify with her daughter and regain legal custody, 2) obtain her GED and a college degree, and, 3) terminate her SSI and work as a counselor.

Case #2: Mr. G is a 28-year-old married father of two and an immigrant from a former Soviet-Block, Eastern European country. He has a psychiatric diagnosis of Major Depressive Disorder-Severe with Psychotic Features with multiple admissions to the mental health treatment center for depression and suicide attempts. In three years prior to admission to Project Redirection, Mr. G had two arrests related to a conviction for vehicular hit and run. Total jail days were 216. The arrest that precipitated the referral to Project Redirection was for a probation violation for failure to make restitution payments on his conviction. He was admitted to the program in December 1999.

Mr. G has very limited English skills and requires the use of an interpreter for all of his interactions with program staff. His psychiatric history began when he was held in a prisoner of war camp in his native country and was

subsequently hospitalized for his psychiatric symptoms after his release from the POW camp. He witnessed numerous brutalities and the murder of his best friend in the camp. Symptoms of depression and suicide began at this time. They were increased upon arrival to this country four years ago.

Upon release from jail he returned to his wife and children. His entry into the program presented numerous practical and psychiatric challenges due to language and cultural issues. He continued to experience significant depressive symptoms characterized by profound feelings of failure and significant and frequent thoughts of suicide. There were frequent admissions to the crisis and inpatient units. Due to concerns for his safety, Mr. G moved into Southside House – the project's short-term residence. He remained there for two months.

During his stay at Southside House he continued to experience feelings of failure and thoughts of suicide. He was frequently preoccupied with thoughts of death, self-harm and failure as a husband and father. An important turning point occurred when it was discovered that Mr. G had never discussed his mental illness with his wife. The treatment team (psychiatrist, case manager, probation officer, house staff) met with Mr. G and his wife and discussed his illness and his feelings that have plagued him.

Another intervention occurred when the probation officer worked with Mr. G, the judicial system and the Office of Revenue Reimbursement to reduce his restitution payments to an affordable level. Additionally, his case manager was successful in expediting his SSI application. He now receives SSI and continues to reliably meet his restitution obligation.

Currently, Mr. G is doing well. He has not required psychiatric hospitalization in several months. He meets with his psychiatrist regularly and is medication compliant. His participation in groups is limited due to his limited English. His current goal is to re-enroll in English classes thus increasing his ability to participate more fully in his treatment.

SAN BERNARDINO COUNTY

SPAN (San Bernardino Partners Aftercare Network) Project

Case #1: DS is a 44-year-old Caucasian male who appears older than his reported age. He has a history of mental illness, which was first diagnosed at the age of 8. He was born to alcohol-addicted parents who were unable to provide for his care. He was institutionally raised and was approximately 30 years old when he was released from the in-patient mental health system.

DS has diagnoses of Schizophrenia, Paranoid Type, Alcohol-Induced Psychotic Disorder with Delusions, and Learning Disorder, Nos. He reported a 15-year history of alcohol abuse. His delusional behaviors have resulted in self-injurious acts of pushing wires and pencil lead into both ears. He has been a vagrant for the past 14 years, and would hitchhike from state to state by car and train. He reportedly has not resided in any location for more than a couple of months. He reported numerous arrests for public intoxication and vagrancy. He was arrested in San Bernardino County for public intoxication and assault on a police officer.

This client was released from custody as a demonstration group participant on 9/28/00. His treatment plan includes board & care placement, five day per week alcohol/drug outpatient program, random testing and psychiatric treatment.

DS continues to reside at the board & care facility. He actively participates in chores and activities within the facility. He continues to maintain sobriety and work though the steps of his program. He rides public transportation to his program with other residents of his board & care. He has not re-entered custody or required hospitalization, has successfully maintained a consistent and stable environment, and is medication compliant. DS has developed a strong support system, and has a "best friend."

Case #2: Hazel is a 32-year-old Afro/American female who was arrested for battery. She is married with 4 children ages 15, 11, 9, and 2. She has been diagnosed with HIV since 1996. Her husband was recently released from prison.

She has had difficulty obtaining housing due to her prior evictions, which lead to a "transient" lifestyle for her and her children. Hazel is in the MIOCR demonstration group. Since her release in July 2000, she and her children have obtained a 2- bedroom apartment through our Department's housing program. She is also in the process in looking for a house in order to accommodate her children's growing needs. She consistently sees her medical doctor for her health. Her children had been stable as far as attending school and doing well in school. She has been very self-sufficient in accessing her needs. She utilizes her case manager when she has difficulty accessing services or resources. She consistently pays her fines and is able to budget her money in order to meet her family's daily needs. She has not returned to jail nor has she been admitted to a psychiatric hospital.

SAN DIEGO COUNTY

The Connections Program

Case #1: On 05/18/2000, Ms. R was sentenced to 180 days custody and placed on formal probation for 3 years in two separate cases of trying to cash forged or altered checks. Ms. R is a 34-year-old single woman who was the victim of sexual abuse as a child, and a runaway from a dysfunctional home as a teen. While employed and self-sufficient for a time as a young adult, she has been unemployed and frequently homeless for the past 10 years. She denied stealing or altering checks, but admits to cashing them for the people who did. She was able to survive on the streets with the money she was paid to do this.

While incarcerated, Ms. R was diagnosed as Bi-Polar and was prescribed Zyprexa and Depacote. She was screened and found suitable for the Connections Program and, on 05/22/2000, was released from county jail to Team "C". Prior to release, a Personal Service Plan was developed for the client. The Team collaborated with the client to formulate a plan by which the client would work herself into a functioning position in society while remaining law-abiding and successfully completing probation. This Service Plan involved finding suitable living arrangements, obtaining psychiatric care, as well as much needed dental care, and applying for SSI or learning vocational skills to boost employment options.

Immediately upon release, Ms. R agreed to live in the St. Vincent De Paul Center, a homeless shelter downtown where she completed the short-term entry level, Challenge to Change Program. She is currently in a two-year program of long-term transitional housing. She is taking classes in adult education and relapse prevention. She has remained drug and crime free, having no positive drug/alcohol tests, and no new offenses. St. Vincent's also provides for her psychiatric needs and has tended to her dental needs.

With the Team's assistance, Ms. R obtained EBT for food, General Relief and applied for SSI. The original application for SSI was denied and an appeal was filed. The Team helped the client in connecting with the Legal Aid Society of San Diego to support her SSI appeal. During this time the Connections program's Employment Specialist contacted Ms. R, giving her employment guidance and assisting her in applying to City College for computer training courses. Prior to attending computer classes, however, the SSI appeal was approved and Ms. R lost interest in both areas.

In September of 2000, General Relief notified Ms. R that an active felony warrant had been issued in her name. Research by the Team disclosed that a new case for trying to cash an altered check had been filed and a warrant had been issued. It was further revealed that the offense had occurred prior to the two cases for which Ms. R was currently on probation and, therefore, did not constitute a "new" offense or a violation of probation. With the Team accompanying her, Ms. R surrendered on the warrant and was released on her own recognizance to the Connections Program. She pled guilty at the arraignment, and on 10/31/2000, with a favorable sentencing recommendation due to her positive performance in the Connections program, was given another 3-year grant of formal probation with no time of incarceration, and released to the Program.

It would appear that Ms. R has accomplished everything she set out to do according to the original Personal Service Plan. Her first statement to the team at the initial meeting was that she wanted to be independent in her own apartment. With her SSI funding, she is on the verge of accomplishing that goal. The Connections Team will prepare the client for her transition into the community with support and information.

Case # 2: Jonathan is a 26-year-old Caucasian single male. He was born in Michigan, but raised in Escondido, California by both parents. He graduated from high school and completed one year at Palomar College, where he played football. According to Jonathan's mother, two of Jonathan's best friends were killed in a DUI vehicle accident, and Jonathan felt guilty because he was not with them.

At age 18, Jonathan tried Peyote and wound up in a mental hospital for 22 days, where he was diagnosed as bipolar. He has used cocaine and pot. At the time of his arrest, he was drinking a pint of Tequila daily, as well as beer. According to Jonathan's mother, approximately five years prior to his arrest, he had been hospitalized for Manic Depression. Upon release from the hospital he stopped taking his medication.

The four years prior to his arrest, Jonathan worked as a bouncer at the Dream Girls Strip Club; Jonathan is quite a large man, 6'2", weighing about 270 lbs. He is a weightlifter. On 10/8/99, Jonathan was arrested for being drunk in public and threatening police officers. Jonathan was fired from his job when, according to him, he went manic and was abusing the patrons. On 11/11/99, Jonathan returned to the Dream Girls Club, from which he had been fired three weeks before. Jonathan was acting irrationally and appeared to be under the influence of a controlled substance. When asked by the manager to leave the club, Jonathan threatened to "kick his ass." The police were called and Jonathan was arrested. After arriving in jail, he continued to threaten the manager by phone.

On 11/22/99, Jonathan was arrested for returning to the Dream Girls Club in violation of a Restraining Order. He was also charged with petty theft of a cellular phone and resisting arrest, by leading the police in an auto chase and threatening the officers once he was detained.

On 12/25/99, Jonathan threatened to kill a woman he got into an auto accident with and ran away from the accident scene. Jonathan then went to a friend's home and attacked and physically assaulted the friend, who was watching TV with his girlfriend.

On 12/29/99, prior to his court hearing, Jonathan was yelling profanities at Marshal deputies and refused to come out of his cell. He was escorted to court by five deputies. After his arraignment and being denied release, Jonathan became angry and yelled obscenities to the judge. He struggled violently with the five deputies, who attempted to restrain him. Jonathan spat in one deputy's face and violently slammed him into a doorjamb. Due to the violence, Jonathan was in solitary confinement 24 hours a day after this incident.

Connections' first contact with Jonathan was made on 4/25/00, when he was assessed for appropriateness for the Program. Jonathan was diagnosed with Psychotic Disorder NOS and a GAF of 10; medication - Zyprexa and Depakote. On 5/2/00, Jonathan was re-interviewed and was advised he had been selected for the program and a treatment plan was developed.

On 5/25/00, Jonathan was released from jail, where he was met by his Connections Team and his mother. Jonathan returned to his parent's home, where he lived prior to his arrest. Initially, Jonathan's mother was extremely anxious about his condition and fearful that he might become violent again. The team had frequent contacts with his mother to provide support and reassurance. As a result of intensive team intervention, her fears did not materialize.

The Connections Team assisted Jonathan in locating the classes he needed to meet his conditions of probation and Jonathan has been persistent on following his court orders since his release. He has completed Anger Management classes at the North Inland Regional Recovery Center. He also successfully completed the Dual Diagnosis Drug and Alcohol Treatment Program there. He has been attending NA/AA classes regularly and has tested negative for all drug and alcohol tests given to him by both North Inland Regional Recovery Center and Probation.

The team also worked with Jonathan to make arrangements for his ongoing psychiatric care. Jonathan is being seen at the North Inland County Mental Health Clinic for ongoing psychological counseling and psychiatric treatment. The team social worker carefully monitored his mood and assisted the client in communicating with his psychiatrist. Jonathan has been taking his medications regularly as prescribed by his doctor.

Initially, Jonathan spent most of his time on the couch and was resistive to activity of any kind. The team felt he was "mourning" his prior life style, which was based largely on substance abuse. Through daily contact, the team encouraged Jonathan to venture out. Jonathan has been able to obtain full-time employment with a company doing phone collections. He has been with them for almost three months and has already been promoted. He has been able to use his income to start paying back his restitution fines.

Jonathan reports feeling much better mentally, and now seems to have a positive outlook regarding his future. The Connections staff believes Jonathan will remain successful if he continues with mental health treatment and continues to abstain from drugs and alcohol.

SAN FRANCISCO COUNTY

Forensic Support System (FSS)

Case #1: A.J. is a 42-year-old heterosexual African-American man who has been repeatedly incarcerated in S.F. County Jail (almost always for drug charges). He has been diagnosed with Schizophrenia, Paranoid Type, Post-Traumatic Stress Disorder, Crack Cocaine Dependence, with rule-out diagnoses of Psychosis due to General Medical Condition and Cognitive Disorder NOS. He also has an Axis III diagnosis of Head Trauma from an event last year where he was hit on the head, abducted, and sexually assaulted by strangers. A.J. currently lives in a dual diagnosis residential treatment program that is part of the San Francisco Community Mental Health system. However, for most of his treatment with our project, A.J. has lived with his wife and 3-year old daughter in an apartment. He has been a client in our program since 1/26/00 and was released from custody on 2/18/00.

Most prominent in A.J.'s presentation are his extreme paranoid delusions, visual hallucinations, innocent demeanor combined with a robust, boisterous, friendly voice, and his openness toward discussing his crack cocaine addiction and the conflictual feelings evoked prior to the first of the month when he gets his check. A.J. frequently arrives in the clinic at 8:30, smiling nervously while saying "They tried to follow me off the BART but I lost them," and will then attend three groups at our clinic, typically Check-in group, a SAMM group, and another group such as Goal-Setting or Anger Management. A.J.'s treatment experience at our clinic is also characterized by two brief (approximately 15-20 minutes) meetings with his clinical case manager and by sitting in the client-run café talking with peers and whomever on the Forensic Staff passes by during the course of his day. A.J. will be occasionally disruptive in groups, bouncing up to be sure that no one is outside the door, but is usually redirectable and can usually finish the group.

We have had a strong fit between A.J.'s needs and our current hybrid model of clinical case management combined with both ACT and day treatment aspects. A.J. benefits from having a strong primary relationship with his case manager where he can cultivate sufficient trust in order to discuss issues around his assault and pre-morbid functioning that he has not discussed with others on the team. Yet, A.J.'s impaired attention span and high level of distractibility, at least in great part due to paranoid ideation, render him unable to tolerate long meetings with his case manager. This fact, combined with his need for and responsiveness to frequent reassurances of safety from others, has made somewhat of a team approach rather helpful for A.J. He will often rather pleasantly and endearingly speak briefly with 5-7 forensic staff daily when he randomly encounters them on site, saying things like, "I think they got in here. What should I do?" Staff will respond, "We're here to keep you safe and have this be a safe place. I'm glad you're telling us. When I'm on my way down I'll be looking around. Meanwhile you'll be OK here until the next group." He will usually smile and say "OK. OK."

While A. J. continues to use crack, his use now is concentrated around the first of the month as opposed to using more days than not. Despite some clear cognitive impairments, his case manager has worked persistently and skillfully with A.J. so that he has developed some ability to plan ahead for the first of next month, citing places he'll go, things he'll do, and how to implement these plans, rather than using crack. He takes his psychiatric medication consistently, and actually frequently requests PRN's of Haldol for his paranoia. A.J. has not been rearrested since his 2/18/00 release from custody.

As A.J.'s treatment evolves, components of the Forensic Support System other than Citywide Case Management Forensic Project are playing a more prominent role in his system of care. A.J. spent about five weeks in a Community Substance Abuse Services (CSAS) residential treatment program from 7/25/00 to 9/00 and has since transitioned to a more appropriate dual diagnosis residential treatment program through San Francisco Department of Mental Health Services (DMS). In addition, San Francisco Adult Probation Department's two designated officers for our project's clients have played a pivotal role in providing reality testing to A.J. around the legal consequences of his potentially going AWOL from treatment. Through A.J.'s recent transition to residential treatment, his clinical case manager with Citywide remains an active presence in his life and fulfills our commitment to continuity of care, meeting at least weekly with him and working closely with both the residential treatment staff and A.J.'s family. We will continue to enjoy playing a role as the process of A.J.'s treatment unfolds.

Case #2: B.S. is a 32-year-old African-American male diagnosed with Chronic Paranoid Schizophrenia complicated by crack-cocaine abuse. He has a 10 year-plus history of repeated arrests primarily drug offenses, and was discharged from San Quentin 7/00 with parole until 04/01 and treatment as a condition of parole.

The oldest of three boys, B.S. was sent to the California Youth center in Sacramento at age 12 after an incident of lewd behavior with another child. The client was socially isolated with no significant work history. His father died when B.S. was a senior in high school. The client married and divorced twice, and has an 8-year-old son in the San Francisco Bay area. He has no contact with his brothers, but is close to his mother.

B.S. initially refused psychotropic medications and residential treatment, denying he had a mental illness and a drug problem. He had no entitlements, so his case manager helped him get food stamps and General Assistance while applying for SSI. Citywide Forensics Team subsidizes his hotel until the project can get him SSI. The client liked coming daily to our morning coffee, doughnuts, and check-in group, but was unable to participate in groups as he was guarded, delusional, hallucinating and angry. We finally were able to hospitalize the client for grave disability, but not before he pushed another client at the facility. The Citywide program advocated with Psychiatric Emergency services and the Parole Office not to arrest B.S. (for the pushing incident) but to hospitalize him because he was grossly psychotic.

Despite his inpatient stay, the client continued to refuse medications. His case manager would meet with him daily but only outside the facility (in cafes) because of safety concerns when he is in an unmedicated state. Additionally, the case manager told B.S. that he could not report treatment compliance to his Parole Officer if he was too disorganized and volatile to participate in groups. B.S. really likes hanging out at the center, getting food baskets, or watching the weekly movie, and he did not want to return to prison, so he agreed to injectable antipsychotics. Since medication compliance, his functioning has dramatically improved, he has returned to the facility and participates in two groups a day. Additionally, he has been referred for vocational training and part time work.

SAN MATEO COUNTY

The OPTIONS Program

Case #1: Paul is a 50-year-old Caucasian male with co-occurring disorders of schizophrenia (onset in his early 20's) and alcohol dependence. He has an extensive history of non-compliance with mental health treatment, homelessness, and repeated incarcerations. His hospital record includes many Psychiatric Emergency admissions as well as several hospitalizations and numerous admissions to a psychiatric sub-acute facility. His arrest history and problematic behavior in the community have made him notorious with the local police departments, district attorneys and judges. Most of Paul's arrests were related to his alcohol use and refusal to remain on his prescribed psychiatric medications.

Paul was admitted into the OPTIONS Program in early March 2000. Initially, he seemed reticent and suspicious; however, his case manager was able to bond with Paul and gain his trust. The case manager encouraged Paul to contribute to his treatment plan by participating in goal setting and problem solving. Providing positive reinforcement, and identifying and building on Paul's skills and intelligence, have been instrumental in the progress that has been attained to this point.

Paul was admitted to a sub-acute facility upon his release from jail where he stayed approximately 5-6 months. During his stay, his case manager was in contact with him on a daily basis - working with him on improving his living skills, money management skills and his social skills. Additionally, Paul's alcohol dependence was addressed and he attended Dual Diagnosis groups and individual therapy sessions. Upon his discharge from this facility, Paul spent a short time in a shelter that provides 10 beds for OPTIONS clients. With assistance from his case manager, Paul enrolled in an intensive outpatient drug and alcohol-counseling program where he attends weekly dual diagnosis groups and individual sessions. In mid-November, Paul moved to a County-contracted residential facility. He continues with his counseling at the drug and alcohol facility and is also enrolled at Vocational Rehabilitation Services.

In December 2000, Paul had a slip and drank ½ of a beer. He reported this slip to both his case manager and to his probation officer. When questioned about the nature of his slip, Paul was able to demonstrate understanding and insight into what led up to it, and was also able to explain how and why this slip did not lead to a full relapse. His insight into his internal process was marked and impressive.

Paul continues to demonstrate increased insight into his behaviors and genuine understanding of his mental illness and his substance use. He and his case manager are in the process of finding another residential home where Paul will be able to remain on a long-term basis.

Case #2: Jimmy was the first client admitted to the OPTIONS Program. He is a 40-year-old male who was admitted in February 2000 after being referred to OPTIONS by the County jail. His latest arrest and conviction involved a misdemeanor that referred to "inappropriate conduct." Jimmy has a diagnosis of paranoid schizophrenia and a criminal justice history that includes disturbing the peace, resisting arrest and battery. At the time of his most recent arrest, he had been receiving mental health services at one of the County clinics for over ten years. Throughout this time, he was not consistently med-compliant nor did he follow through with staff recommendations that he receive treatment for his substance use. Jimmy's treatment had, over time, evolved into crisis intervention, incarcerations and hospitalizations. Due to his disruptive behavior, he was regularly discharged from Board and Care facilities and motels. Jimmy would usually spend approximately four nights a week at a low-cost motel/hotel and the rest of his time on the streets. Because of his mental illness, he has been a target for drug dealers for many years. He would often buy drugs with the hope of possible friendship as a reward.

After his admission to OPTIONS, Jimmy was transferred to a sub-acute locked facility in an attempt to provide stabilization. Within a week of his admission, he engaged in a physical altercation with another resident and was returned to the jail. He remained in custody for 48 hours and was transferred to a homeless shelter upon his release. His case manager worked with him to get him stabilized by transporting him to all of his appointments (medical, etc.), and by linking him with other services in the community. This task was considerable given Jimmy's history and his paranoia. He was extremely mistrustful of his case manager at first, and presented numerous interpersonal challenges. This attitude was apparent with all staff, including his probation officer. During this time, staff consulted with the

prescribing psychiatrist, who determined that a medication modification might be beneficial to Jimmy. He was prescribed a different neuroleptic and an anti-depressant. Jimmy was also referred to an ongoing Dual Diagnosis group.

Interpersonal skills remain a challenge to Jimmy. His case manager spends considerable time educating him about social interactions, appropriate behavior, reality testing, budget issues, and basic life skills. This is a difficult task, given that Jimmy experiences long-standing delusions as part of his mental illness, (i.e. he believes that he is a famous rock star, and the founder of numerous successful companies). His delusions have made it difficult for him to accept and sustain daily employment. In spite of this, Jimmy has engaged in periodic work. During these times he has demonstrated enthusiasm, pride, responsibility and an increase in self-esteem. Interspersed with these periods of achievement, Jimmy tends to react with significant resistance to structure, daily responsibilities, etc. His case manager has been superb in gently confronting Jimmy about his resistance, and interjecting reality with regard to the behavioral means necessary to attain goals. To achieve results, the case manager has instituted a behavioral reward system that reinforces Jimmy's positive behaviors that allow him to experience success in the community. Currently, Jimmy is providing "peer transportation training" to other OPTIONS clients, by helping them to understand the public transportation systems that exist in the County, and how to effectively use them.

Prior to his admission in OPTIONS, Jimmy was perceived as someone who, due to his behavior, would most likely remain homeless, resistant to treatment, and in a state of decline. Mental Health providers, Criminal Justice and Alcohol & Drug had all but exhausted ideas and attempt to connect with him. Although Jimmy continues to face challenges in daily life, he is truly an OPTIONS success.

SANTA BARBARA COUNTY

Mental Health Treatment Courts (MHTC) with Intensive Support Teams

Case #1: M. is a 22-year-old, never married Mexican-American male. He claims an 11th grade education. Record review stated that M. was a ward of the court as a juvenile due to chronic truancy and drug use offenses. He was enrolled into a probation school at age 17 for approximately six months until his 18th birthday. At that time, M.'s juvenile probation was terminated and he stopped attending school. He reported having an employment history of a job as a dishwasher at a restaurant lasting one month at age 19. He has a documented and significant substance abuse history as a juvenile and an adult including abuse of alcohol, marijuana and methamphetamine. As an adult, M. was placed by probation at two residential substance abuse treatment programs. He completed neither program, being uninterested in drug treatment, and left the second program after only 10 days. Additional previous community residences have included his mother's home, friends' homes or the homeless shelter. M. has also lived "on the street" for short periods. Previous primary mental health diagnoses have included Dysthymic Disorder; Psychotic Disorder NOS; Schizophrenia, Undifferentiated Type; Amphetamine Abuse.

M. was admitted into the program from county jail in April 2000. At that time, he was homeless and had no identification or possessions except the clothes he was wearing upon his release from custody. Initially, he stayed at the homeless shelter because he had no source of income to pay for a room anywhere. (The program had no emergency housing funds to assist him.) As monitoring his daily activities was difficult for staff due to his lack of a residence, M. was in-and-out of jail on several occasions in the coming weeks for failure to comply with his treatment plan, being under the influence of drugs, and use of alcohol. The MHTC probation officer facilitated M.'s returns to custody.

Over time, with the help of the case manager assigned to him, M. secured a birth certificate and, subsequently, a state ID card. With those documents, the case manager was able to assist him in applying for and receiving General Relief funds. This money enabled M. to secure a room in a sober living house. He has since been relocated twice - to a Board & Care and another sober living house. His frequent non-compliance with house rules and arrests cost him his placements at these previous residences.

With closer supervision, the staff has been able to begin working with M. to stabilize his psychological and social functioning. His mental health diagnosis was clarified (Schizophrenia, Paranoid Type), he was started on psychotropic medication, an application for SSI was submitted but denied (M.'s case manager is assisting him in an appeal decision), and he began participating in program activities on a regular basis.

Program generated or sponsored activities for M. have included an educational group module called "Community Re-entry" that focuses on effectively using mental health services; a substance abuse educational/treatment group series; regular drug testing; a "Horticulture" activity wherein clients obtain hands-on experience in growing various plants and flowers with the goal of developing work habits and specific skills; attendance at AA meetings; self-paced remedial reading, spelling and math instruction at the local community college; and frequent appearances in the MHTC (generally weekly) to monitor his participation and progress.

In recent months, M.'s level of psychological and social functioning has greatly improved – but not without several setbacks. He periodically uses drugs and alcohol (resulting in additional jail time), and is often non-compliant with his medication regimen, which results in psychological decompensation and increased failure to participate in the program.

M. shirks responsibility for advancing the goal of living more independently (his mental illness aside). Intensive case management continues to be necessary in order to help M. maintain any sort of stable living arrangement.

Current goals for M. include being abstinent from drugs and alcohol, increasing medication compliance, establishing consistent participation in MIO activities, and appealing his denial for SSI. With the continued support from the Intensive Support Team and MHTC staff, M. has achieved more stable psychological and social functioning than he has experienced in recent years. Maintaining that stability is the challenge now.

Case #2: Ms. A is a Caucasian, divorced female in her late 30's who has three teenage children. When she started out in Mental Health Treatment Court 13 months ago, all her children were in foster case with relatives due to CPS concerns, due partly to Ms. A's history of being the victim of domestic violence, several losses including the death of her mother and brother, as well as drug and alcohol abuse. One of her daughters was repeatedly missing after running away from her foster home.

Ms. A entered Mental Health Treatment Court on a pre-plea basis with charges of public intoxication as well as resisting arrest. She was referred directly from jail to her first appointment at the local County Mental Health Facility. She was given an Axis I diagnosis of Bipolar I Disorder, Severe, Without Psychotic Features, as well as Alcohol Dependence, had a medication evaluation by a psychiatrist, and was prescribed psychiatric medication, which she has been taking consistent with her prescription.

The MHTC housing specialist facilitated immediate entry into a very structured and supportive clean and sober living environment upon discharge from jail, financially supported by Ms. A's Social Security Income. Initially Ms. A participated in two AA meetings a day, successively dropping down to 4 AA meetings a week. After an initial standard two week restriction period at this sober living environment, she started a three times a week MHTC community re-entry program, with an emphasis on learning social and independent living skills.

After her successful completion of this two-week course, she entered a three times a week MHTC dual diagnosis program called the Substance Abuse Management Module, which emphasizes developing behavioral skills to maintain sobriety, such as practicing relapse prevention. During her three-month participation in this course, she had her first significant setback. As she found out that one of her daughters had ran away, and as she was faced with additional coinciding stressors, she was emotionally overwhelmed and she turned to drinking. However, with continued support from MHTC staff, she was able to regain her sobriety quickly, successfully completed her dual diagnosis program, and has, except from one other brief relapse, been able to stay clean and sober and maintain a relatively stable mood.

Ms. A began volunteer work while at MHTC, completed the Sheriff's Work and Training program, and now holds a paid job. She has during her treatment at MHTC, with assistance from her MHTC case manager and the Department of Rehabilitation, been able to reenter school. She did not participate in the MHTC horticulture program as, by the time this was up and running, she was already committed to other jobs.

She has during this program been able to turn around her family life, having taken the first steps toward a reunification process with two of her children. She is currently living a clean and sober life style at a highly structured clean and sober living environment (with the daughter who previously kept running away from foster homes). Ms. A's graduation from MHTC is expected to take place within six months.

SANTA CRUZ COUNTY

The MOST (Maintaining Ongoing Stability through Treatment) Program

Case #1: Richard is a 35-year-old bisexual Hispanic male who was referred to the MOST Team in November of 1999 while in the county jail on a probation violation for a positive cocaine test. Richard has a 10-year history of schizophrenia and has spent a substantial portion of the past 7 years in prison on cocaine related violations. He also receives intermittent treatment for AIDS.

Richard has a history of suicide attempts and cut his wrists while at San Quentin. Richard received no psychiatric treatment while he was in prison. He was kept in isolation due to his paranoia and HIV status. Upon his release on parole, he was referred to outpatient mental health for treatment. However, his treatment compliance was intermittent, and he often relapsed into cocaine use. At the time of his referral, he had been living in his own apartment and was non-compliant with both his psychiatric and HIV treatment. He was physically ill and had lost 50 pounds. He was complaining of his hair falling out and had fungus under his fingernails.

Richard agreed to participate with our project when we contacted him in the jail. He expressed a desire to maintain sobriety and improve the quality of his life. His father was contacted by the team and has been very supportive his treatment plan. We placed Richard in a board & care facility from the jail. He was hearing voices and was very paranoid at that time. His physical health was fragile. At this facility he was stabilized on psychiatric medication and his HIV treatment was continued. His physical and psychiatric condition improved considerably over the next few months.

During this period the team's psychiatrist and his nurse/coordinator were able to visit him at the board & care home regularly to monitor his treatment. His condition improved to the extent that he no longer needed to reside in a board and care facility. The team referred him to a social rehabilitation facility where he currently resides. The team assisted him in purchasing a spa membership and he attends several times a week. His physical condition has improved remarkably.

Approximately 4 months ago our psychiatrist adjusted his medications to a point where he reports no longer hearing voices. He has not been rearrested and is now off parole. He has made two trips to Lake Tahoe to visit his father recently without incident.

At this time his family states that he is in the best condition they have seen in 10 years. Richard has been treatment compliant and clean and sober for over a year. He is starting to prepare to move into independent living.

Case #2: Emily is a 24 year-old white, unmarried female with a comorbid diagnosis of social phobia and major depression with psychotic features, as well as severe alcohol dependence. Since 1997, she has had 21 arrests and 13 admissions to the local mental health unit for alcohol related problems. She has also attended several residential treatment facilities and either did not complete them or relapsed shortly after discharge. In 2000, prior to being assigned to the MOST team and her subsequent placement in Paloma House (a three-month residential treatment program for adults with a dual diagnosis), she spent 192 days incarcerated in the local county jail.

Emily's family has a positive history of mental illness and substance abuse with her father suffering from obsessive-compulsive disorder and her grandmother suffering from alcohol dependence.

At age four, Emily was sexually abused by a male perpetrator, at age nine she began displaying obsessive-compulsive behaviors and rituals (hand washing in excess of 50 times per day), and by age thirteen had discovered that drinking made her "not care so much what people thought" and "relaxed me." "I could be more honest and brave." Emily left high school early and received her GED. By the time Emily was 17, she was experiencing the severe consequences of alcohol dependence. She was a passenger in a car accident in which she broke her neck, back, ankle, and elbow. Both she and the driver (her boyfriend) were extremely intoxicated at the time. From this point, Emily's condition began to deteriorate and she has suffered seizures, head injury, repeated BAL over 300, peripheral neuropathy, pancreatitis, alcoholic hepatitis, and panic attacks.

During her incarceration in 2000, Emily was receiving treatment from the jail psychiatrist and had been prescribed psychiatric medication for the symptoms of depression and anxiety. When Emily was approached about her selection for the MOST program, she was already working on her sobriety, and was therefor intrigued by the prospect of people being interested in her recovery and cautiously accepted the proposal of support and guidance.

After her intake to the team, the MOST team psychiatrist conducted a psychiatric evaluation and made some medication changes while she remained in custody. Her probation was transferred to the team and we petitioned the court to allow her to do the remainder of her jail sentence in a dual diagnosis treatment program. She was placed in the program on November 1,2000.

While at the program, Emily received regular visits from the psychiatrist, her coordinator, the case aide, and our MFT intern. All have worked with her regarding symptom management, sobriety, and new ways of being in the world. Emily graduated from the program February 1, 2000 and returned home to live with her parents.

Emily now has eight months clean and sober. She continues to work with the team and has made tremendous progress. She attends AA meetings regularly, volunteers with a local organization that packages groceries for home-bound seniors, participates in activities sponsored by the MOST team, and actively works at gaining new skills and information.

Her goals for the future include going back to school, independent living, gainful employment, and a life free from the clutches of chemical dependency and mental illness.

SONOMA COUNTY

The FACT (Forensic Assertive Community Treatment) Program

Case #1: J.G. has been known to Sonoma County Mental Health since 1980. At that time he was living with his mother, who brought him in for treatment secondary to increasing paranoia and suspiciousness. His case was opened in Adult Outpatient services at that time; he was followed in the medications clinic only; and he was diagnosed with Paranoid Schizophrenia and Methamphetamine abuse. He was maintained on injectable medications but frequently missed med appointments, and there was no capacity for outreach or follow-up. His drug problems were not addressed as part of his mental health treatment, other than clinicians advising the client of the negative impact on his symptoms. He only had two hospitalizations in this 20-year period.

At some point, J.G.'s mother left the area for Florida and J.G. became intermittently homeless, living in room and boards or on the streets. In 1990, 1997, and 1998, he was booked as under the influence of a controlled substance. In 1991 he was booked and charged with petty theft. It was not until 1998 that residential treatment and random drug testing were included in his court orders. He had at least two Failure to Appears and two bench warrants issued. {He opted to serve time rather than probation at that time.}

J.G. came to the attention of the FACT program in March of 2000 after being booked on felony possession of cocaine. He was referred to mental health court, was sentenced and became the first FACT client. He was referred to A Step Up for treatment of his addiction but was unable to handle the stress of the program expectations. He became more psychotic despite intensive interventions by his psychiatrist, and threatened to "break out a window" at the program. Staff became alarmed and asked him to leave. At that point we felt that he was not in a position to be hospitalized nor did he warrant re-incarceration. The clinical team instead responded to the client's "real" experience of stress related to the treatment expectations, and we lowered them.

J.G. "wanted" his freedom but he was willing to cooperate with all terms and conditions of probation other than residential treatment. We found him a room and board, escorted him there, placed him on a mediset for medication monitoring, saw him initially 4-5 times a week, and tested him frequently. He had one positive test for cocaine initially. He was brought in front of the judge in mental health court for a review, and heard about the potential consequences of future positive tests. From that time forward we have had no positive tests.

J.G. is going to Interlink and AA meetings as instructed. He is psychiatrically stable, taking his meds, and is happy with his current living arrangement. He makes all scheduled appointments. He is now doing well enough to be seen only weekly. He recently was accompanied on a "shopping" trip for clothing and initially thought he would buy his things where he has been shopping for many years, at the Good Will. However, with the help of a representative payee, J.G. has some funds with which he was able to shop at a department store for clothes for the winter.

We learned that finding J.G.'s treatment "set point" where he was comfortable and the treatment team was comfortable with his compliance, has been the key to his current success.

Case #2: K.E. is a 42-year-old female who was admitted to the FACT program in June 2000. She came to our attention while in custody for a DUI (alcohol.08%) and felony burglary. She had multiple bookings in 1999 for disorderly conduct with alcohol; willful cruelty to child; under the influence, and petty theft. K.E. has a long psychiatric history starting in childhood, when she was sexually molested by a family friend and by her stepfather. She began using drugs around age 12-13. She had multiple psychiatric hospitalizations for out of control behavior and threats of suicide prior to age 20. She actually attempted suicide once by overdose and once by a serious threat to jump out a hospital window.

Her mental health contacts in our system began in 1993 when she presented requesting medications for depression and racing thoughts. She was always inconsistent in her follow through with many missed appointments. In 1996 she was hospitalized and seen at that time as Bipolar I, Alcohol abuse, and a Personality disorder. She was referred for Outpatient case management and stayed in treatment on and off for two years. Her outpatient case was closed in 1998 for lack of contact. Her criminal activity locally started in 1999.

Upon admission to the FACT team, K.E. had physical custody of two minor children, so the team attempted to engage with her by wrapping mental health and drug treatment services around her in a non-residential fashion. She immediately began to miss drug treatment groups and testing appointments. She did test positive for heroin and was re-incarcerated (after allowing several positive breathalyzers). Her children went to live with her mother and she waited in jail for placement in residential treatment.

Upon release in residential treatment K.E. demonstrated immediate cross addiction behavior by having unsafe sex with an HIV + resident in the program. When confronted with this behavior, she AWOL'ed from the program. She was then picked up on a new DUI charge and re-incarcerated. Again it was felt that residential treatment was the level of care she needed and she willingly reapplied to the program. She sat in jail waiting for a bed to open and, when it did, a written contract was developed which she and all parties agreed to regarding her behavior and participation in the program. She was able to finally engage in the program, started working the twelve-step model, and was utilizing her support system appropriately.

K.E. periodically verbalized a desire to use or have sex but she managed to abstain. Staff noted her progress. She had never successfully completed residential treatment before. Six to eight weeks passed. This past weekend she was involved in a fistfight with another resident (reportedly fighting over the attentions of a resident to whom she is sexually attracted). She was re-incarcerated since the program will not tolerate any violent behavior. She has been invited to re-apply again. We believe this case clearly describes the difficulties of treating the dual diagnosis client. We will continue to work with K.E. but eliminating jail days as a consequence will be a challenge.

STANISLAUS COUNTY

ACT (Assertive Community Treatment) Program

Case #1: Melanie G. is a 38-year-old, single, Caucasian female who was assigned to the Forensic Assertive Community Treatment (FACT) Team in February 2000. She has been diagnosed with Psychotic Disorder, Not Otherwise Specified (with a rule-out diagnosis of Schizophrenia, paranoid type), Post-Traumatic Stress Disorder, and Other Substance Abuse (with a rule out diagnosis of Polysubstance Dependence). She was referred to the FACT Team because of her lengthy history of mental illness and recurrent involvement with the criminal justice system. Though she has had problems since she was an adolescent, Melanie lacks insight into her mental illness. In addition to her belief that she was born with the special ability to be a prophetess, she also thinks that her body is a house for different spirits to dwell in, including the Devil. Also, she hears voices of different people "guiding" her to do things.

In school, Melanie desired what most children wanted, to have friends and to be like everyone else. Because her particular mental illness causes her to isolate from others, she felt she had no friends while in her school age years. Not knowing what to do to be "normal," Melanie was easily drawn into the use of drugs by a distant relative. She discovered that when on drugs she experienced a feeling of being normal and believed she was well liked. She also, paradoxically, would have fewer symptoms of psychosis when on drugs. Her experimentation soon led to regular abuse of methamphetamine and alcohol. By the age of 20, Melanie was dependent on substances. When obtaining drugs for free was no longer an option, she resorted to theft and selling illicit substances. In the past three years, Melanie's involvement with the criminal justice system has revolved primarily around drug offenses and violations of probation. Her latest incarceration in February 2000 made her eligible for the program.

It should be noted that prior to her entrance into the FACT Team, the client had never received mental health services or substance abuse treatment on a sustained level. This was partly due to her reluctance in complying with treatment recommendations and her unwillingness to show up for medication and mental health appointments. Her lifestyle of continuing to abuse drugs in order to self medicate further alienated Melanie from her family members. This disruption caused everyone in the family to feel helpless in dealing with Melanie's addiction and mental illness. Their subsequent withdrawal of support by turning her away left Melanie with only a SSI income and drug abusing associates.

Initially, the client was not very willing to engage in treatment with the FACT Team. Utilizing the principles of the Assertive Community Treatment model, as well as the implementation of innovative engagement strategies, the clinical and probation staff was able to attract and maintain Melanie's interest in mental health/substance abuse treatment. The FACT Team Deputy Probation Officer also supervised her and assisted her in the avoidance of behavior that might lead to re-arrest. The FACT Team met regularly to identify antecedents to Melanie's criminal behavior and discuss the employment of harm reduction and relationship based strategies. Over time, she developed a more open and trusting relationship with her case manager and the FACT Team.

To date, the FACT Team has proactively influenced a variety of activities for Melanie. Through collaboration with the Probation Department, Court and Counsel, the FACT Team was able to design conditions of probation that sought to encourage the client's involvement with mental health services. These have included psychiatric, intensive case management, substance abuse and probation services. She has attended her medication appointments on a regular basis and works collaboratively with the FACT Team Psychiatrist and Nurse around medication issues. Concurrently, and as part of an integrated behavioral health and recovery services system, Melanie attended an intensive outpatient (IOP) drug treatment program nine hours a week at a county regional behavioral health and recovery center.

In addition to the behavioral health and recovery services, the FACT Team's Deputy Probation Officer is able to bring in a probation component to the treatment framework of the interdisciplinary FACT Team. Through regular visits with the FACT Team's Deputy Probation Officer, she participates in random drug testing. For the past eight months, Melanie has tested negative for any illicit substances each time the random drug test was administered.

The relationship between the staff and Melanie continues to grow and develop as communication improves. She has asked that her case manager assist her with financial management by becoming her SSI representative payee.

Reciprocal to the trust she has shown the team and her improved level of personal and social functioning, Melanie's family members have rekindled their relationship with her. She has been invited to not only visit her mother, aunt, cousins, and grandmother, but to stay with them whenever she pleases. In addition to this "Homecoming," the family has a great deal of gratitude for the FACT Team. They wish to let the MIOCRG Program know, with Melanie, that their quality of life has significantly improved. The FACT Team remains hopeful that Melanie will continue in her recovery and have no further problems with the criminal justice system.

Case #2: Thomas Q. is a 42-year-old, single, Caucasian male with a lengthy mental health and criminal history. Though he denies having any mental health problems, Thomas displays active symptoms of a major mental illness, such as paranoid ideas and poverty of thought and/or thought blocking. He has a primary diagnosis of Schizophrenia, paranoid type. His secondary diagnosis is Other Substance Abuse, by history. In addition, Thomas meets the criteria for Antisocial Personality Disorder and he has an Axis III diagnosis of leg and back pain.

Thomas has been in the mental health system since he was a child. He has a history of 36 involuntary psychiatric hospitalizations, to include a period of conservatorship and treatment for a few years at Napa and Atascadero State Hospitals. Thomas comes from a family system that may be genetically and environmentally predisposed to mental illness and involvement with the criminal justice system. Many of his family members were, and continue to be, mentally ill with significant periods of time spent in state mental health institutions.

Thomas' symptoms are complicated by his substance abuse. He started using methamphetamine when he was about 30. He is not able to articulate his rationale of why he started using drugs. However, we do know is that he was identified as having a serious major mental illness at an early age. He has historically refused to engage in mental health or substance abuse treatment. Family members who were available to assist the client in decision-making were not present in a manner that provided any constructive support. Subsequently, mental health and law enforcement agencies became his support system.

Unfortunately, Thomas' situation in the past may have reflected the lack of systems integration. Although he was often psychotic at arrest and during incarceration, his behavior was not viewed as severe enough to warrant involuntary psychiatric treatment. Post-incarceration referrals to voluntary outpatient mental health programs were unsuccessful because the client did not recognize his need for treatment. Therefore, he would be held in custody without any consistent psychiatric treatment and subsequently released to the streets. Because of these service gaps, Thomas spent many years roaming aimlessly between the street, jails, and state hospitals. His extreme paranoia and delusional thinking largely precipitated his involvement in the criminal justice system. For example, there was an incident where the client perceived a man whom he had never met before to be his rival. He heard voices telling him that the man would come and hurt him. Thomas believed these internal voices and became threatened. In response to this perceived stress, Thomas responded by brandishing a knife and went after the other individual. The police arrested Thomas and he was subsequently charged with a felony for which he is currently on parole with the California Department of Corrections.

Thomas was assigned to the Forensic Assertive Community Treatment (FACT) Team on January 18, 2000. The Assertive Community Treatment model made various intensive mental health services available. The services include (but are not limited to) medication, group therapy, case management, individual therapy, drug and alcohol services, recreational activities and legal services.

The FACT Team soon came to realize that Thomas' needs for self determination and his right to privacy had to be considered. Attempts to contact this irascible individual were met with extreme opposition. The FACT Team met to discuss strategies to engage him in a manner that Thomas would not perceive as threatening or intrusive. Essentially, the FACT Team needed to engage him where he was at the time and to array resources around him. His case manager, through a gentle and consistent manner, was able to support Thomas' need for isolation by offering sporadic treatment contacts. During this engagement phase, Thomas' Parole Officer would also meet with him on a regular basis. By collaborating with the FACT Team, the Parole Officer was able to motivate Thomas towards accessing the services available to him through the FACT Team. This understanding and compassionate approach has produced a dramatic result within the past year. Thomas has kept more appointments in the last 10 months than he had in the past three years. This increment of success has not been without setbacks. Thomas continues to insist on living independently and manage his SSI income even though he has significant deficits in his ability to care for his basic needs of food, clothing and shelter. Recurrent destabilization of his psychiatric condition with subsequent involuntary hospitalization has occurred.

Recently, Thomas was placed on a three-day parole hold at the county custodial facility. Prior to his release from jail, the FACT Team case manager and Deputy Probation Officer were able to collaborate with the Parole Officer, custodial staff and the inpatient psychiatric facility. The result of this jail pre-discharge planning was Thomas' release from custody and transfer to our local psychiatric inpatient facility on a 5150 commitment for grave disability. The FACT Team's proactive participation with the inpatient facility treatment team has resulted in a recommendation from the treating psychiatrist for Representative Payee status. This will require Thomas to accept his case manager's assistance with the management of his SSI income.

The level of interaction between Thomas and the FACT Team remains tenuous, at best. Developing a strategy that balances the client's desire for self-determination and privacy with the need for treatment continues to be the primary focus for the FACT team. However, it is clear that without FACT Team intervention, including collaboration with Parole, Thomas would not be receiving any mental health services.

APPENDIX F

EXECUTIVE STEERING COMMITTEE
FY 2000/01

BOC Members

Chief Taylor Moorehead, Los Angeles County (Chairperson)
Sheriff Lou Blanas, Sacramento County (Co-Chairperson)

California State Association of Counties Representative

Supervisor John Flynn, Ventura County

California State Sheriffs Association (CSSA) Representatives

Sheriff Keith Royal, Nevada County
Chief Norm Hurst, San Bernardino County, CSSA Detentions and Corrections Subcommittee

Chief Probation Officers of California

Chief Melton Losoya, Yolo County

State Department of Mental Health Representative

Tom Wilson

State Department of Alcohol and Drug Programs Representative

Patricia Hill

California Mental Health Directors Association Representative

John Anderson, MFCC, Deputy Director, Humboldt County Mental Health Department

APPENDIX G

MIOCRG PROJECTS AWARDED FUNDING IN MAY 2001 (IN RANK ORDER)

VENTURA COUNTY will create the MART (Multi-Agency Referral and Treatment) Program, which will provide specialized court processing, probation supervision and enhanced services to misdemeanant mentally ill offenders.

The centerpiece of the MART project is the Augmented Services Program (ASP), which will provide comprehensive psychiatric treatment combined with rehabilitation, counseling, housing, probation supervision, and vocational and case management services (including transportation) within the context of the assertive community treatment model. The multi-disciplinary ASP team will also provide predisposition services. Non-violent misdemeanants may be given formal probation supervision and released on their own recognizance, which will technically mean release to the ASP team. Violent misdemeanants will be referred to MART only after adjudication and completion of their sentence. One judge will be dedicated to the MART calendar. The county will be expediting the in-custody assessment and referral of offenders with mental health problems.

YOLO COUNTY will establish Project NOVA, a community-based intensive treatment program that will provide the following specialized services:

- A culturally and linguistically competent psychological assessment within eight hours of intake.
- Case management, drug and alcohol treatment, and extensive release planning while in custody.
- Up to 90 days of transitional housing upon release from custody.
- Up to 275 days of post-custody assertive community treatment, which will include case management, daily reporting, individual and group therapy, drug and alcohol treatment, drug testing, vocational and socialization education, medication management, crisis intervention, housing, and transportation.
- Up to 90 days of transitional level treatment and supervision, if needed, following the assertive community treatment phase.

To support compliance with treatment and conditions of probation, a dedicated court calendar and dedicated probation officer are also part of this effort.

SAN JOAQUIN COUNTY will create the Mental Health Court Project, which will involve a special court to handle mentally ill offenders and a program of assertive community treatment.

The Mental Health Court will produce a sentencing plan that includes mental health care, substance abuse treatment, and social services. Discharge planning will begin 3-4 weeks prior to an inmate's release and will include setting up appointments with specific service providers and initiating the application process for public benefits and entitlements. Each client will be assigned to one of three multi-disciplinary Assertive Community Treatment teams and will receive ACT services for an average of six months.

Because many participants will be ordered to the Day Reporting center in Stockton, the county will expand the center's capacity to provide services, which include peer mentors, medication management, relapse prevention (including random drug testing), and assistance with locating and securing employment.

MARIN COUNTY will implement a demonstration project encompassing the following components:

- In-custody assessment, treatment, and discharge planning.
- Assertive community treatment, case planning, and case management provided by a multi-disciplinary team on a 24/7 basis.
- Community-based mental health, physical health and medication support.
- Provision of ancillary services, including temporary housing support, dual diagnosis treatment, transportation, money management, access to entitlement and benefits, and basic needs support.

The county will provide training on mental health issues to local law enforcement officers and each local agency will have a mental health liaison.

MONTEREY COUNTY will establish the MCSTAR (Monterey County Supervised Treatment After Release) Program, which will include the following components:

- In-custody Assessment and Treatment Services
- Mental Health Court
- Forensic Assertive Community Treatment Team (with a 1:10 staff to client ratio)
- Cognitive Skill Training Program (36 two-hour sessions over the course of eight weeks)
- Supervised and Supportive Community Housing (treatment furlough beds, augmented board and care beds, supportive housing beds, single room occupancy units, and rent subsidies)

SAN FRANCISCO will implement the Connections Program, which will target mentally ill offenders released from jail as part of the Sheriff Department's Supervised Misdemeanor Release Program or Supervised Pretrial Release Program.

The project will manage clients through their court cases; provide a stabilizing environment that includes psychiatric and substance treatment as well as housing; assist with the acquisition of entitlements; create work opportunities; connect the client to community-based treatment programs; and provide ongoing education to community providers. The county will contract with the Progress Foundation to provide the community-based treatment and case management for clients. The Sheriff's Department will be working with the Tenderloin Neighborhood Development Corporation and the Department of Public Health Housing Coordinator to acquire rooms in single room occupancy hotels for temporary housing.

BUTTE COUNTY will implement the FOREST (Forensic Resource Team) project, wherein three multi-disciplinary teams will provide integrated intensive services to eligible mentally ill offenders.

- A Jail/Intake Team will provide early contact and screening, discharge planning, and data collection for clients in the jail.
- A Court Team will be involved with the new MIOCR Court, which will be modeled after the county's Drug Court, and a Forensic Coordinator will serve as liaison between the court and all elements of the project.
- A Community Treatment Team will provide enhanced intensive services, including clinical treatment, substance abuse counseling, and case management (e.g., vocational services, assistance in applying for SSI, housing, etc.).

To ensure that housing is available, the county will partner with the local Alliance for the Mentally Ill (AMI), which will hold the lease on five three or four-bedroom houses in Oroville and Chico to be sublet to clients who are capable of living in a group setting. The grant will provide rental and utilities subsidies so that AMI can provide the housing at lower than market rents when clients cannot afford more. Emergency housing will be available in local motels and shelters.

TUOLUMNE COUNTY will implement the CARES (Crime Abatement Rehabilitation/Recovery Enhancement Services) Program, an intensive in-jail and post-release community based program that will be administered by a four-member Intervention Team comprised of two behavioral health clinicians, a jail classification officer, and a probation officer – all of whom will be cross trained. This team will work with Public Defenders, the District Attorney, Judges, Behavioral Health Services, Social Services, Probation and community-based organizations in coordinating conditions of release, intensive discharge planning, and treatment options. The Intervention Team will also collaborate with an existing multi-disciplinary effort in the county, the Homeless Outreach Services Team. All CARES participants will receive, at a minimum, mental health counseling, probation surveillance, and housing, vocational and clinical assistance. The level of other services, including education, family support, financial counseling and advocacy, and life skills training, will vary depending on need.

MENDOCINO COUNTY will establish a Mentally Ill Offender Therapeutic Court (MIO-TC) and a Sentencing Alternative for Mentally Ill Offenders program (SA-MIO).

Eligibility for the MIO-TC, which is modeled after the county's Adult Drug Court, will be determined by the District Attorney and supervision will be provided by the existing Therapeutic Courts Administrator and by the proposed Therapeutic Court Management Team.

The SA-MIO is a court supervised 24-month five-phase treatment program that will include the development and monitoring of an Individual Case Management Plan (ICMP) by an Intake Assessment Team and Clinical Services Team. The ICPM will address the individual client's goals and service needs, which may include supportive, transitional housing. The county will be providing motel and rental assistance vouchers to MIO-TC clients. A Post MIO-TC Support Program will also be created to provide after-treatment care focused around preventing lapses/relapses through ongoing support, additional life skills training, medication management, peer mentoring, etc.

ALAMEDA COUNTY will implement the Mentally Ill Offender Graduated Services Program, which addresses the identified need for discharge planning, case management, intensive short-term transition supports and aftercare services.

As a part of this effort, the county will fund staffing and related services needed to ensure the early and intensive identification of inmates booked into the jail who have mental health need. The grant will fund the remaining program components, as follows:

- Enhanced in-custody services, via a contract with a private agency, including discharge planning.
- Short-term (30-60 days) intensive case management services upon release from custody.
- A transition housing program involving vouchers (five rooms a night).
- An aftercare program called CHANGES for dually diagnosed clients.

LOS ANGELES COUNTY will establish the Reducing Criminal Recidivism in Dually Diagnosed Incarcerated Mothers project, which will include a jail-based integrated treatment program for eligible offenders who are pregnant and/or who have minor children, and an intensive case management program following release from custody.

The jail-based program will include integrated psychiatric and substance abuse treatment, parenting training, and rehabilitation approaches aimed at developing skills necessary for independent community re-entry (housing, occupational and financial stability). As part of this effort, the county will be developing a set of operational procedures that will enhance the identification of the target population.

SAN BERNARDINO COUNTY will establish the Passages Program, which will involve intensive in-custody treatment and recovery services and community-based treatment and case management services upon release:The in-custody services (3-12 months) will include intensive mental health therapy, substance abuse treatment, occupational therapy, and medical support five hours a day, five days a week.

The post-custody services (9-12 months), which will be provided by multi-disciplinary Regional Services Teams in four geographic areas, will include comprehensive mental health treatment, medication management, drug testing, case management, probation supervision, transportation and transitional housing (up to 30 days).

SOLANO COUNTY will implement the Mental Health Court Project, which will combine court sanctions and a comprehensive system of enhanced residential and community-based services. The project will involve:

- Creating a Mental Health Court that will use graduated sanctions, depending on the severity and frequency of non-compliance, to support the treatment process.
- Providing comprehensive in-custody mental health assessments that will be used in making recommendations for treatment or behavior management to the court and in discharge planning.
- Establishing three Assertive Community Treatment teams that will provide intensive case management, supervision and support services to clients for a period of 3-12 months.
- Expanding the existing Forensic Assertive Community Treatment team to ensure the continuation of a high level of services to clients, as needed, for an additional 6-12 months.
- Creating a 12-bed crisis residential program on the grounds of the Claybank Correctional Facility to offer wraparound services for up to three months to clients whose condition is so severe they cannot immediately return to the community.
- Providing specialized mental health training to law enforcement and judicial personnel.

KERN COUNTY will implement the Rural Recovery Dual Diagnosis Treatment Program, which will serve the Eastern Kern County communities of California City, Ridgecrest, Mojave, Tehachapi and Lake Isabella. The program will involve four months of residential treatment in a 10-bed facility licensed as a board and care home; eight months of intensive outpatient follow-up in one of two sober living environments; and, as appropriate, ongoing case management and treatment via an existing Mental Health team.